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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Growing up and showing the doctor how fast—a familiar scene in a pediatrician's office. "For pediatricians the paramount goal is prevention of illness," says Dr. Robert J. Haggerty, in the leading article in this issue, and he discusses some of the special skills which he believes must be built into pediatric training if this goal is to be accomplished.

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Today, the medical profession faces a pressing need and an unmatched opportunity to examine and modernize the training physicians who will be caring for tomorrow's children are receiving. The pressing need comes from the increasingly severe professional manpower shortage and from the growing realization that for many people in this country the breakdown of health begins in early childhood. The opportunity comes from the recent breaches in the economic barriers that for so long have kept good medical care out of the reach of many families and children.

In focusing this article on postgraduate pediatric education, I am assuming that by the time physicians receive their medical degrees they have already learned a good deal about the normal growth and development of children and have developed basic skills needed to obtain data from interviews, physical examinations, and laboratory tests. Postgraduate education should refine such basic skills and add many more.

It seems self-evident that postgraduate training of physicians to meet the medical needs of children should be related to the health problems faced by children today. However, it is sometimes difficult to incorporate this principle into the hospital internship and residency programs through which postgraduate education is obtained. As White and his associates have pointed out, the patients seen in teaching hospitals are a decidedly biased sample of all the sick people in the community.[1] A great many of the health problems of children do not automatically come to the attention of physicians in training in university hospitals.

Children's health problems

Children's health problems are of three general types: (1) conditions that cause death; (2) conditions that cause morbidity, acute and chronic;[2] and (3) parental anxieties. (Robertson[3] has demonstrated that a majority of mothers of newborn babies suffer anxiety about the baby's feeding, breathing, bowel movements, or some other normal function.) The pediatrician in training needs experience with problems of all these types. He also needs experience with the social conditions of the families in which children are reared, for whether or not the child lives in a healthy family or social environment has a great bearing on his present and future health.[4, 5]

Although pediatricians in training must gain

PEDIATRIC TRAINING and the MANPOWER PROBLEM

ROBERT J. HAGGERTY, M.D.

knowledge of and experience in the diagnosis and management of children with illnesses serious enough to warrant hospitalization, this is not enough. For pediatricians the paramount goal is prevention of illness; and prevention requires special skills. One important skill is the ability to detect vulnerable groups—the groups of children in the population who are most likely to develop ill health. Because we have yet to identify all such children clearly, it is difficult to teach methods of prevention. However, we have identified some of these groups. They include premature babies, babies born to families having a history of genetic disease, babies of mothers who have had no prenatal care, and children of nonwhite, low-income families in city slums.

Traditionally, hospital-based pediatric training programs have emphasized the diagnosis and management of the acute illnesses that cause morbidity and death and have given less attention to the techniques of primary prevention and early diagnosis of such common and treatable presymptomatic problems as incipient vision and hearing disorders or to the management of complex handicapping conditions such as cerebral palsy or emotional disturbance. They have given even less attention to training pediatricians in the diagnosis and management of the underlying social and family problems that affect illness patterns or to training in methods of seeking out those families in the population who are resistant to medical care though they may have the greatest needs. The morbidity in this hidden group of nonpatients has been likened to the hidden portion of an iceberg—much greater than the part that is seen.[6]

All children need some preventive services, but it is wasteful to provide those not at great risk the same services needed by those at high risk of developing irreversible impairment. Thus a major task for the pediatric profession in the immediate future is to find out more about who the most vulnerable groups are, how they can be identified, what to do about them when they have been identified, and how to provide the kind of setting for physicians in training that will stimulate them to develop these skills.

Some valuable experience in ways to approach this task is now being gained in universities with maternity and infant care and children and youth projects supported by the Children's Bureau. For example, in the family continuity program at the University of Rochester, pediatric residents are now learning skills needed to care for "high-risk" children in low-income areas.

Continuity of care

Many teachers of pediatrics believe that the first goal of postgraduate training is to provide the physician with enough experience in diagnosing and treating the common serious and acute illnesses of children to make him thoroughly competent and comfortable in managing them. I do not deny the importance of this traditional aspect of pediatric care, nor do I suggest that training time spent on specific diseases should be in proportion to their frequency. But I do feel it important to emphasize certain additional aspects that in many places do not receive enough emphasis today.

With a good basic medical school education, the

pediatrician in training in most university hospitals and the larger community hospitals can develop skill in the diagnosis and treatment of specific illnesses during 2 "core years" of postgraduate training, consisting of a year of straight pediatric or mixed pediatric-medical internship and a year of residency. The problem that remains in most training programs has been the inability to provide the trainee with sufficient experience in the management of consecutive episodes of acute illness in the same child. Yet most pediatricians are convinced (in the absence of experimental findings one way or the other) that continuity of care is more effective than episodic care, that it requires special experiences to learn how best to provide such care, and that training programs must somehow achieve this goal. A few experiments are now under way to provide such experience in the required second year of pediatric residency and the recommended third year of residency.

No training program has been able to provide continuity of care for all of the patients it tends, but in recent years many have developed special programs for small groups of patients under a variety of names—"comprehensive care," "family health," "continuity care."[7, 8] Most of these programs provide physicians with 1 to 3 years' experience in caring for the same children. While this is admittedly limited continuity from the family's standpoint, it is far better than no continuity at all, the norm for most persons who use teaching hospitals as their central source of medical care. Such medical school programs as the family health care program at Harvard University, the family continuity program at the University of Rochester, and the family health program at Yale University are examples of these small-scale teaching efforts. The next step is to develop continuity of care for all children who receive their medical care from hospital clinics, a difficult but necessary task.

Robert J. Haggerty, M.D., has been in the Department of Pediatrics, University of Rochester School of Medicine and Dentistry, as professor and department chairman since 1964. Formerly, he was with the Harvard Medical School as assistant professor of pediatrics and director of the family health care program, one of the training programs in comprehensive pediatrics cited in this article. He is also engaged in research in methods of providing health services.

Most of the new teaching programs that provide continuity of care to some patients offer both preventive and curative services for the children included in the program. True, the few children that any one physician can care for during his internship and residency training make these programs a bit "precious." They do not give the physician a realistic idea of how he will have to function in practice when he is faced with the enormous demands of an expanding child population. However, they do offer the trainee his first opportunity to develop the skills entailed in providing preventive services, skills that take a great deal of time to acquire.

The training experience

A key to the success of these introductory continuity programs is the provision of an adequate number of competent, experienced, and enthusiastic teachers and the careful selection of the families to be served. Most of these programs stress the skills involved in developing good doctor-patient relations; in diagnosing and managing developmental disorders; and in taking into account the social components in health and illness, the role of the family, and the role of the health team in providing continuity and comprehensiveness of care. To achieve their purpose, they usually try to give the pediatricians in training experience with families from various social classes and educational backgrounds, and having various kinds of problems.

In such programs the trainees cannot be expected to learn "on their own." To expect them to do so denies the need for this type of program entirely, for if no "teaching" were necessary, physicians could wait to develop such skills until they are in practice. The value of such training during the residency training period is that then the residents can test out different methods of providing pediatric care without the pressures of time that will occur in practice; through seminars they can probe deep into present knowledge about ways of providing comprehensive pediatric care; and, perhaps most important, they can work with the teaching staff to study and improve pediatric methods, thus contributing to what Romano has called "cumulative knowledge,"[9] a body of knowledge that can be added to by each generation of doctors and transmitted to others.

In addition to teaching methods of care, the faculty of some of these programs engages in research into new methods of delivering services and transmits to the trainees an ability to evaluate such methods criti-

cally and continually as a part of their function as clinicians. This kind of teaching is expensive, but no more so than the teaching of biomedical research, an accepted part of most residency training programs.

Areas for experimentation

Because the health of the child is closely related to the well-being of other members of his family,[10] a growing number of these special training programs are emphasizing a family focus in the care of children.[11, 12] In these experiments, all children in a family receive first-contact medical care from members of the same health team (usually consisting of physician, nurse, social worker, and, in some instances, auxiliary health workers) and efforts are made to secure greater knowledge than usual about the parents, their background, way of living, and problems.

An experiment is under way now in Boston to determine how much difference, if any, it makes in the health of children for them to have medical care provided with a family focus.[13] If this and other experiments prove that family-focused care is the better method, we shall have greater incentive to develop skill in family diagnosis and therapy in a combined program for internists, obstetricians, and pediatricians and even to promote the training of general family practitioners.

After many years of teaching continuity care within the walls of a teaching hospital, I have come to the conclusion that teaching hospitals, while admirably organized to care for and teach consultative care, are not the best sites for providing primary care nor for the training of house staff in these comprehensive family-focused programs. They are usually too remote from the patients they serve, their staff members find it hard to shift from consultation to primary care, and they present unavoidable administrative blocks such as long waits to register, impersonal staff attitudes, a size frightening to many patients, and special difficulties in establishing family record systems.

However, the new neighborhood health centers being established in many communities with the help of the Office of Economic Opportunity, the health centers for migrant agricultural workers established with funds from the U.S. Public Health Service, under the Migrant Health Act of 1962, and the projects for the comprehensive medical care of children and youth being established in low-income areas with support from the Children's Bureau, under the 1965 amendments to the Social Security Act, provide ideal opportunities for training pediatricians in the neighborhoods where their patients live.

Well-child supervision, an activity that occupies 50 to 70 percent of most pediatricians' time, has generally been poorly taught. New approaches to this aspect of pediatric care, derived from experimentation and study, are especially needed. Prevention should not be separated from curative medicine. Moreover, in view of our serious shortages in medical manpower, it is unrealistic to teach pediatricians in training that the doctor is the only person who can provide preventive services or that such services must always be provided on a one-to-one basis with every patient receiving the same services. I believe that, to be a realistic preparation for the future, pediatric training must provide physicians with experience in caring for a large number of patients in the most efficient way. Thus a goal for the third year of postgraduate training would be to make the resident proficient in the use of techniques for screening children needing special attention and for working with parents in groups, although these processes in practice will usually be carried out by other members of the health team.

Manpower problems

A review of some figures on medical manpower will show why the physician cannot be expected to provide all the services needed. In recent years the number of physicians available to deliver continuing primary medical care to children has steadily declined in relation to the child population. While in 1940 there were 345 general practitioners per 100,000 children under 15 years of age, in 1961 there were only 135 per 100,000, a decline that has not been offset by the increase in pediatricians from 7.3 to 16.3 per 100,000.[14] The average child under 5 years of age receives outpatient attention from a physician about six times a year. Roughly 60 percent of all child-physician contacts are in a physician's office; 5 percent, in the child's home; 15 percent, in a hospital clinic; and 20 percent, through parents by telephone.[15]

If the proportion of general practitioners in the population continues to decline at the current rate and if children are to have from pediatricians the same number of physician contacts they have now, we will need 115,000 pediatricians by 1980 in contrast to our present 15,000! Generous estimates indicate that only about 135,000 physicians of all kinds will be practicing between now and 1980.[16] Clearly we

cannot expect the great majority of these physicians to devote themselves to the medical care of children.

True, some demands on pediatricians may be unnecessary. Many middle class mothers have been led by both the press and members of the health professions to expect "magic" cures for self-limiting illnesses and to have little confidence in their own child-caring abilities. However, we know there is a great deal of real, unmet medical need, especially among low-income groups. For example, infant mortality rates are higher in this country than in 10 others and the highest rates here exist among those portions of our population with the least amount of medical care. Provisions in this country for early diagnosis and adequate treatment of presymptomatic chronic conditions such as vision and hearing defects, environmentally produced developmental retardation, and emotional and orthopedic problems leave much to be desired. Also, lack of available medical care and the presence of social problems have put the early diagnosis and appropriate treatment of acute infections such as otitis media, streptococcal infections, and meningitis beyond the reach of many children.

All of these unmet needs will produce greater demands for health services as programs are developed to remove the economic barriers to medical care and reach out to the unserved portions of our population. To expect to solve the manpower problem through decreasing parent the unnecessary demands of parents is an illusion.

The health team

One suggestion that holds promise for alleviating the manpower problem is to recruit persons other than physicians to carry out, as members of a health care team, some of the services long expected of the physician.[17] But this raises some as yet unanswered questions: Which of the physician's current functions should other health workers carry out? To whom can they best be delegated? What effect will this sharing of the patient have on the doctor-patient relationship?

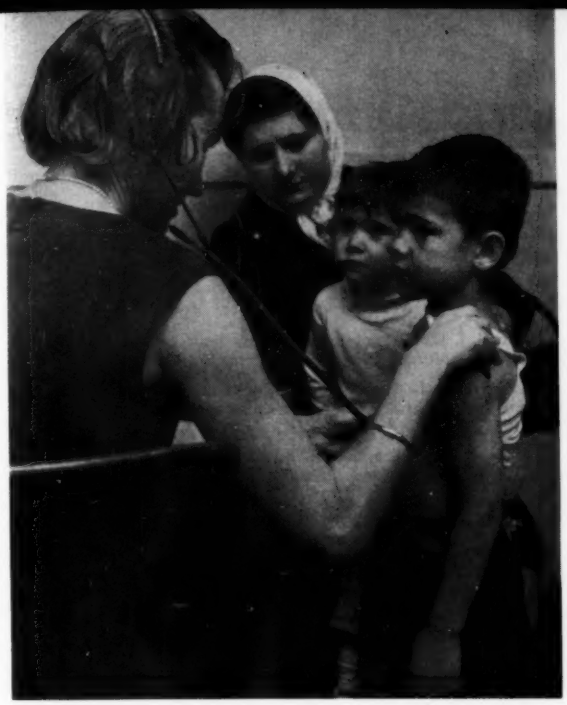
Nurses naturally come to mind first as the most appropriate persons to carry out such services. They have a long tradition of working with physicians and seem more acceptable to patients than members of other allied professions.[18, 19] Unfortunately, they too are in very short supply and their hospital-based training does not adequately prepare them for the tasks needed in an ambulatory setting. Public health nurses, who are perhaps best equipped to carry out some of the physician's present functions, are in even shorter supply. Nurses who have retired from employment to raise families do represent a significantly large pool of unused manpower, however, and comprehensive care programs might experiment with ways to recruit and reeducate them. Their maturity and practical experience in raising families would seem to be advantageous for the tasks that would be expected of them.

How much and what type of training this type of "auxiliary physician" would need is not known, nor is it known whether it is better to give such an auxiliary worker a shorter initial training course than is usual in professional training followed by continued inservice training with all members of the health team or to continue to require the long initial training period customary in our professions. Experiments are needed in the training programs of all health professions to determine whether they can be made less rigid and still give training broad and deep enough to enable the trainee to adapt to changing problems and to make independent judgments, or whether they must continually lengthen initial training programs, as has been the trend in the past two decades.

But even though we experiment with new ways for physicians and nurses to function on the health team and with altering their training accordingly, there is little hope that an adequate number of members of either profession can be prepared to meet the needs in the next decade.

We need more experimentation in the training and use on health teams for mothers and children of persons indigenous to the neighborhoods being served. Such workers have been found, especially in the developing countries, to be effective in bridging the gap in communications between professional persons, most of whom are of middle class origin, and the population with the greatest health needs, the low-income, uneducated portions of the population.[20] A similar communication barrier between professional workers and the patients they serve frequently exists here, especially in programs serving slum neighborhoods.

However, far from being only second-class medicine for the poor or being necessary only until more professional people are trained, a health team that includes neighborhood workers may result in more effective (as well as less expensive) medical care in all types of neighborhoods, even in the affluent suburbs, than does the present system.



Well-child supervision, as provided by this pediatrician in a neighborhood health center, occupies 50 to 70 percent of the modern pediatrician's time, a fact with important implications for pediatric training and the planning of health services.

For example, we know that a large proportion of children with acute streptococcal disease do not complete the necessary course of oral penicillin, whether prescribed in a clinic or in private practice. Recent studies by Charney and associates show that the personality of the mother and her relation to the physician are important factors in such negligence.[21] Perhaps help in understanding the need for such therapy could be given the mother by a member of the health team who as a mother herself has experienced problems in carrying out a doctor's orders. At the same time this "indigenous health assistant" might bring to the physician and nurse a greater understanding of the needs of their patients and the problems they face.

With specific training for specific tasks, such nonprofessional health assistants might also develop skill in advising mothers on aspects of infant feeding, child care, and child rearing. Before launching any large-scale training program for such workers, however, we need more studies on what the needs of the patients are and the kind of training it would take to meet them.

A major problem in the development of such workers, however, is in determining the degree of responsibility they can be given for making decisions. Obviously, nonprofessional assistants must work very closely with the other members of the health care team not only to benefit from continuing on-the-job training, but also to assure the patient of easy access to professional workers when needed.

For example, in developmental testing, nonprofessional assistants might be trained to perform simple developmental screening tests to determine if certain developmental tasks have been achieved by a given child—a yes or no decision. The more difficult decision of what the results of the test mean and what should be done about them should rest with the professional person.

It should be recognized that one nonprofessional assistant cannot learn to do everything. Protection of the quality of care requires that each such assistant be trained for and function in a limited and specialized area. However, this poses a problem, for several assistants may therefore be needed in the care of one child. Determining the number of such assistants acceptable to patients and staff is a problem calling for extensive experimentation, for at some point the size of the health team can become too large for effective communication.

University programs for training pediatricians are in a strategic position to experiment in combining such new methods of providing care with new methods of training. Not much can be done along these lines, however, unless efforts are also made to train persons for teaching and evaluating methods of care. Such training might be offered through fellowships to pediatricians who have completed 2 years of residency training. Some programs for training teachers in ambulatory care are in fact now in existence at the medical schools of Harvard University and the University of Rochester under Children's Bureau sponsorship.

Chronic care

With the addition to the health team of more auxiliary workers, physicians will have more time to spend on the care of chronically ill and handicapped children. Here the skills of pediatricians are particularly needed, along with the skills of those pediatricians who have developed subspecialties in specific diseases or handicapping conditions. Under present requirements of the American Board of Pediatrics, subspecialization in specific areas such as cardiology or allergy added to the broad base of pediatric training can be accomplished in an additional 2 years after

the 2 core years of pediatric internship and residency. But even the pediatrician who is not planning a subspecialization might well select two, three, or four chronic diseases on which to concentrate during his third year of postgraduate training. In this year he should also learn to work as a member of a health care team, one different from the team for primary care but functioning under the same principles for working together.[22]

It is becoming increasingly difficult for the pediatrician in private practice to provide adequate services in his office for the chronically ill child, for he is not likely to have there the technical equipment or the easy access to consultation of specialists and allied health workers such as medical social workers and physiotherapists that a hospital-based program affords. Thus the training programs have an important role to play in helping pediatricians know how to work on such teams as part-time subspecialists while they are in general pediatric practice.

For example, in the cystic fibrosis clinic of the University of Rochester School of Medicine and Dentistry, which has a full-time staff consisting of a pediatrician, director, and consultants in infectious disease, allergy, metabolism, and other specialties, the continuing care of the children is the responsibility of a few pediatricians who are in private practice but who are specially trained in cystic fibrosis and come to the clinic regularly. Both they and their patients seem to benefit.

In conclusion

In this review I have concentrated on training physicians to understand the kinds of medical services needed by children and to work as part of a health team to meet these needs, rather than on the training of the physician per se. I believe this emphasis is essential if pediatricians are to be prepared realistically to meet the health needs of the children of this Nation.

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Human development is a drama with many actors; sometimes one, sometimes another player has the center of the stage, but in this drama no one player is ever on stage alone.

Dorothy V. Whipple, M.D.*, "Dynamics of Development: Euthenic Pediatrics," *McGraw-Hill Book Co., New York, 1966.

INCONSPICUOUS FAMILIAL DISABILITY

DAVID ANDERSON
ERIC KNOX

Nodding our apologies to the caretakers of good writing and good manners, we have decided that we must begin our essay by talking about ourselves. We are second-year medical students at the University of Minnesota. The curriculum here is set up to leave the summer between the freshman and sophomore years free. During this free period, the two of us, fortified by backgrounds in gross anatomy, histology, biochemistry, and a smattering of other sciences, signed up for fellowships within the pediatrics department—and, more specifically, for work with a group involved in establishing an educational model of comprehensive health care for the children of families regarded as poverty stricken. [Comprehensive Health Services for Children and Youth in Minneapolis, Children's Bureau Project No. 603.]

To call us neophytes in the craft and society of medicine would be charitable. And this is a point we want to establish at the outset: our observations in our encounters with the people that are to be patients in the proposed model clinic were unrestricted by the preformed expectations and conclusions that education and prior experience might sometimes produce—and equally lacking in the acuity that education and experience bestow. We point this out to establish our openmindedness, and we hope that our readers do not at once dismiss our viewpoint as only ignorant and naive.

We spent the first part of the summer helping to launch the initial phase of the project. This involved health screening for preschool-age children in the area the comprehensive care unit is to serve. From the first group of medical histories taken in the project (about 50 in all), each of us chose, with the aid of our advisers, one family to study intensively and follow as its members used the clinic. Our feelings about one of these families prompted us to set down our ideas about the need for a new approach in dealing with the problems of a type of family we think will be more and more prevalent.

The Smith family is noteworthy perhaps only by its inconspicuousness. Its very lack of notability seems to be its greatest liability. This family represents to us a self-perpetuating subterranean mode of existence, removed from and unheeded by the active currents of society. This mode of existence fits no labels because it has not aroused the interest of the labelmakers—the sociologists, psychologists, and public health people. Its "pathology" is just beginning to be understood. Those engulfed in it are the school dropouts, the chronically or intermittently unemployed or unhappily employed, the people of whom nothing is expected. What is so striking to us is that their feelings of suspicion and habits of withdrawal from society, themselves symptoms of pathology, seem to be passed on from generation to generation almost like a dominant gene, the pattern broken only when the pathology is starkly manifested in ways that society recognizes and abhors—alcoholism, crime, and the other diseases for which society has its agencies. Our great agencies, praiseworthy as they are, we feel, are treating only the secondary manifestations of a pathology whose origin and reinforcement are in the family dynamics of the people involved.

Pattern of self-defeat

Perhaps the best way of defining what we are talking about is to describe what we saw in the Smiths. Because of the inexpert nature of our observations we can hope only to make clear the dominant patterns of interaction. The parents and six children, ranging in age from Bill, 18, to Daniel, 2, occupy a house in a shabby section of the city. Mr. Smith does his best as a provider though he is untrained and must resign himself to the uncertainty of changing needs for unskilled labor. What he earns each year is enough to keep his family from serious need, with some aid from the city relief program.

The caseworker who oversees the administration of city funds for this family finds little to arouse the enlistment of her talents since the Smiths are thrifty, upstanding, and seemingly do the best they can.

Their condition cannot be characterized by the more colorful, classical picture of poverty with its images of moiling slums, irresponsibility, crime, and aggression. They are of the displaced, the passive and withdrawn, a segment of society present always, but now, with the increasing complexity and speed of our world, bound to include more and more people.

Our primary concern is the emerging pattern of self-defeat we see in the children of Mr. and Mrs. Smith. We realize that the particular constellation of personal traits and interactions in the Smith family is characteristic of this family only. But we want to show that the family dynamics must be understood if we hope to head off the development of six similar next generation Smith families.

The key to the problems in this family appears to be Mrs. Smith. Her role in the interpersonal relations of the family is more active than her husband's. In contrast to the easy-going Mr. Smith, she is wound tight by anxiety and suspicion. Within her home she appears to function competently; keeping the home neat and clean is obviously very important to her. But her ability to function evaporates when she leaves the security of her home. On one day that we visited the Smiths, she had just returned from an unplanned excursion with her father to the Minnesota State Fair. She had become exhausted almost at once, complained of a severe headache, and asked to be taken home. She said she probably would not have gone at all if she had had time to think about it.

It seems to us that Mrs. Smith is able to maintain at home a rather precarious equilibrium that is seriously threatened if she ventures away. She expresses a variety of prejudices, fears, and dislikes, all of which excuse her from having dealings with her neighbors. She retains strong dependency bonds with her own father and brothers and sisters.

The children

The same patterns of dependency we note in Mrs. Smith are developing in her children. Supporting this is the same type of suspicion and withdrawal.

Bill Smith is a good-looking, husky fellow who, from outward appearance, should have the world on a string—that is, if he were not a high school dropout. As his mother spoke about Bill, we began to understand the familial nature of the withdrawal pattern.

Though tests show Bill to be normally bright, he has never developed much interest in school. In fact, he does not seem to be interested in anything, at least for any length of time. At present he leads a sedentary existence, lounging about the house and demonstrating reluctance to venture away.

David Anderson, left, and **Eric Knox** are second-year medical students at the University of Minnesota. Their observations are based on experience at a neighborhood pediatric clinic in the Minneapolis comprehensive health care program for children and youth supported by the Children's Bureau.

Here's a young man who has withdrawn himself from the world. He has quit every job he has had as his interest began to pall—except for a brief stint as a supermarket carryout boy, a job from which he was fired for being "unfriendly." He has expressed mixed feelings about joining the armed services, feelings that mirror his mother's own ambivalence. She feels that a "hitch" in the Army might provide Bill with the discipline and responsibility he needs, but, on the other hand, that it might be too much for him. The issue was resolved when Bill failed the Army psychological test.

Next oldest is 16-year-old Sandy, a high school junior. She manifests her fear and implements her withdrawal through somatization. She has an atopic allergy, probably for wool, though the allergin has not been exclusively incriminated since her symptoms appear in conjunction with altered emotional status. The school nurse feels certain that the psychosomatic element is of the greater etiologic importance, and Mrs. Smith says that Sandy often uses an outbreak of rash as an excuse to stay home. Sandy's world, like Bill's, is becoming smaller and more insulated as she approaches the time when the healthy tendency for a young person is to move toward independence. Like her mother, Sandy is satisfied with no less than an impeccable house, but outside of housework "she doesn't really like to do much of anything," Mrs. Smith tells us.

The most severely affected child is Tommy, age 13. Tommy's case is the one that brought this family to our attention and made the Smiths "interesting," for only in Tommy has the familial pathology emerged in a way that arouses our interest as healers—he has acute behavioral problems. Having admitted our lack of training, we will not presume to explain the

reasons for the greater severity of Tommy's affliction. Two interesting leads for more experienced observers might be found in Mrs. Smith's assertion that Tommy's birth was certainly the most difficult—"his head was twisted the wrong way"—and in his once close relationship with a maternal uncle who committed suicide several years ago.

In Tommy we see aggression and destructiveness, yet beneath are the same kind of fear and withdrawal as in other members of the family. Except for school he refuses to leave the home, unless it is with his beloved grandfather, Mrs. Smith's father. Tommy feels extremely threatened by persons outside his family—including the neighbors of whom Mrs. Smith is so suspicious. Tommy, like Sandy, often develops physical symptoms. He suffers from headaches, stomachaches, and backaches with no apparent organic causes. He has been receiving special aid in school for a reading difficulty. Tommy's problems are recognized and he will undoubtedly be the subject of much professional attention. We wonder if he might not be the most fortunate of the children.

The three younger children, Kathleen, 7, Penny, 5, and Daniel, 2, do not as yet show the effects of the pattern we have been describing. It is, of course, impossible to know whether their emotional state will deteriorate as they grow older and the influences of the family have had longer to work.

Why take them on?

If the Smiths were minus Tommy, we wonder if they would arouse our nascent professional interest. We also wonder about how much attention this family would receive by those who share our values as products of the middle class from which professional healers, nurses, social workers, and doctors almost always come. For, at first glance, the Smiths would seem to be a benign unit of society and any special interest in them superfluous. Why spend time on them when they seem to be compensated for their weaknesses and are not hurting anyone?

We asked ourselves this question when after a closer look we were trying to formulate pragmatic reasons to back up our feelings that the time should be spent. Perhaps such feelings are themselves the most important reason. The members of the Smith family suffer from a disease that makes them unable to function productively in the world as it is today. Therefore, as a healer one has the responsibility for treating them as best he knows how. With some thought and projection the pragmatic reasons become clear as well.

One can be sure that, without intervention in the natural course of such family pathology, society eventually will be adversely affected by the more malignant forms that such pathology may take. When the suspicion and withdrawal are overlaid with aggression, as in Tommy's case, crime is a possible outlet if the pattern is not interrupted. Or when such traits are overlaid with self-destructiveness, as in the uncle's case, suicide might result. Less spectacular perhaps is the burden that Bill's expectations as one of the chronically unemployed represents as a future drain on welfare funds.

Then there is the fact that treatment of the symptoms—from the somatic manifestations of fears to the financial necessity for welfare—without trying to treat the primary pathology is bad medicine, and, we assume, bad social work as well.

Lacks in treatment

Ideally from here we should proceed to the solutions of the problem we have been discussing and point out how we can update or sharpen our methods, but we simply do not have the answers. All we can do is describe how the Smiths have been dealt with in the past and what we feel has been lacking in this treatment. We will in the end make a very general suggestion about a possible starting point in finding the ways to remedy this lack.

Briefly, the treatment that the Smiths have received up till now has been too late, too fragmented, and too inaccessible. Both the nature of the family and the nature of traditional health resources have contributed to these faults.

It seems to us that prevention of the pattern of self-defeat we see developing in the Smith children is possible, but only through early diagnosis and direct intervention. As we have mentioned, except for Tommy the family does not seem remarkable in the cursory look that most busy health practitioners have time to give. However, of equal importance in the delay of diagnosis and treatment is the Smiths' reluctance to seek outside "interference." Like many people in their condition, they must be convinced that a family member is acutely ill before they seek help.

For the Smiths the primary medical resource is the county general hospital and the charity facilities of one of the community hospitals. Both are excellent establishments. Sandy's emergency record at

the general hospital reveals part of the problem.

In eight different entries, spanning 4 years between 1962 and 1966, the admitting complaint is her acute skin symptom. Even the first examination yielded the diagnosis of neurodermatosis, and symptoms of anxiety were noted then and during several subsequent examinations, but it was over a year from the initial complaint before Sandy was scheduled for the allergy clinic. Although the emotional elements of her disease were suspected from the beginning, the expenditure of effort has been primarily to find a salve for maintaining her complexion—precious time has been lost.

From Sandy's records, and Tommy's as well, the fragmented nature of the treatment they have received is also well illustrated. Again the attitudes of the Smith family toward health agencies—to be used only in acute situations—as well as the nature of the facilities themselves are implicated. The fragmentation we refer to exists within the sphere of medical treatment and, on a larger scale, among the various agencies responsible for health in its broader connotation. For families unable to afford a private doctor, the emergency room provides the only recourse in time of need. For diagnosis and treatment of acute illness or injury, we think, the emergency room is ideal. However, for the chronically ill, for whose treatment knowledge of the development and course of the disease is extremely important, the necessary continuity of treatment is threatened by the turnover of personnel and shortage of time that are the conditions of the emergency room.

The availability of outpatient specialty clinics does not entirely solve the problem. Sandy's attendance at the allergy clinic was only occasional, depending on the severity of her skin condition at the time. Tommy's appointments at the pediatrics clinic were usually kept only when he had one of his headaches. A striking and saddening fact is that in almost every entry in the records of these two young people the examining physician expressed the opinion that emotional factors were involved in their symptoms. That the traditional facilities are partly responsible for the difficulty in dealing with these factors seems to us an unhappy and unnecessary situation.

The cross aims and overlapping aims of the various agencies of the community that in the composite are responsible for health in the larger sense of the word—overall well-being—represent another level of fragmentation. The Smiths have not been the subject of much attention from the various community agencies. But through our concern with them, we have seen how the total pattern of family difficulties may never be discerned by the observations made from single, nonintegrated, though insightful, points of view. The city welfare worker undoubtably knows a great deal about the Smiths' financial expectations. The school has recognized Tommy's reading and behavior problems. A high school nurse perceives the elements of school phobia in Sandy's allergy problem. But who is going to put these observations together, relate them with what goes on in the home, and see the family as a whole?

Intermediary needed

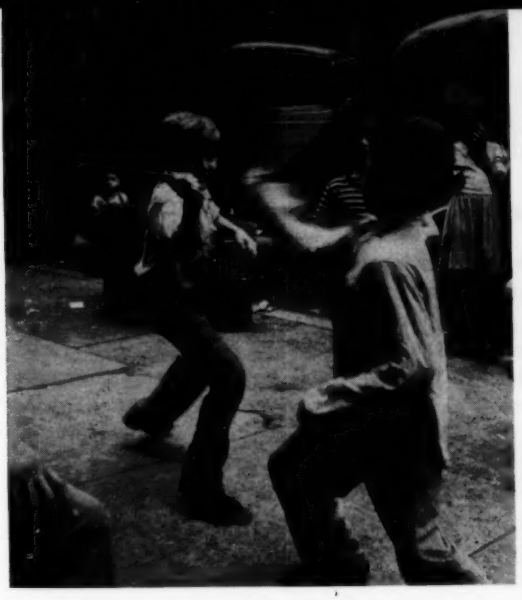
What it all boils down to is that the care the Smiths have received has been inadequate because of its inaccessibility—inaccessibility not in the physical sense or even in the economic sense, but in the sense that a gap exists between the family's needs and the resources of the community. The gap is opened by the aforementioned reasons behind the tardy and fragmented nature of the care the community offers. We feel that it might be spanned and care made accessible to the Smiths by a person or group whose prime function is to gain as complete an understanding as possible of the family and its dynamics, whose prime concern is to prevent disease in all connotations of the word, and whose tools are the specialized agencies already operating in the community.

What we have in mind is an intermediary between the family and community resources, one with sufficient understanding to fit the care to the need. To attempt to go beyond this very general suggestion would rapidly exhaust both our space and our ideas—indeed the questions that arise concerning the ideal training for carrying out such a role, the proper relationship of such an intermediary to the family and to the agencies involved, and financial arrangements possible are those for which answers will be found only through experience.

The Smiths, while unique, have represented to us an example of a growing number of displaced people—removed from the mainstream of today's demanding way of life. We feel that the key to understanding the origin and propagation of their pattern of self-defeat and to averting a predictable course of events is in the workings of the family. Beyond clearing slums, training high school dropouts for employment, and instilling hope in the hopeless, we in this country must find ways of breaking the chains of human interactions that perpetuate many of our social problems.

a psychiatrist considers the origins of

VIOLENCE IN GHETTO CHILDREN



ROBERT COLES, M.D.

When I worked as a child psychiatrist in a children's hospital, I spent most of my time with middle class children whose parents very often seemed earnest and sensitive; certainly they were worried about their children, at times excessively so. The boys and girls, for their part, were usually quiet and controlled. They were suffering from "school phobias" or the various fears and anxieties that have been described by a generation of psychiatrists. If they were disobedient and loud, usually it was a specific form of disobedience I saw, a very particular noisiness I heard, all connected to something they dreaded or dared not to look at. In a sense, then, the unruliness I noticed only confirmed my impression of a general restraint (emotional tidiness, I suppose it could be called) that middle class children by the time they are 2 or 3 years old are likely to have acquired, never to lose.

Yes, there are the usual signs of aggressive tendencies in the "latency years" (the years preceding puberty when sexual urges are quiescent)—the bold and even nasty games, the play that seems involuntarily brutish—until a long look reveals how curiously formal, even restrained, the unruliness of these children actually is. Despite all the "drives" one hears psychologists and psychiatrists talk about—the surges of desire, spite, and hate that continuously press upon the child's mind and in dreams or daytime fantasies gain control of it—the fact remains that by the time middle class American children first reach school, at age 5 or 6, they are remarkably in control of themselves. As a result, when the violence in such children erupts in a psychiatrist's office during a session of drawing or in the midst of a game played by the psychiatrist and the child, it is almost a caricature of violence—violence so safe, so exaggerated, so camouflaged, and so quarantined that the very word seems inappropriate.

We in psychiatry are often accused of seeing only the drab and morbid side of human nature. If it would be any comfort to people, I suppose we could easily make partial amends for that morbid bias by letting it be known how overwhelmingly law-abiding man is: if he is vindictive, he is likely to be so toward himself. Psychiatrists spend most of their time helping people take a look at violence removed enough from their own recognition to be, in effect, somebody else's property. If in time the patient, whether child or adult, owns up to what he secretly or temporarily senses, he will be in greater, not less, control of himself. Thus, I remember treating a 10-year-old boy who drew wild and vicious scenes, filled with fire and death or at least an injury or two. When I wanted to know about what was going on, he

let me know the score rather quickly by pointing to the people in his pictures and saying, "I don't know, you'd have to ask them."

A different "ball game"

Not everyone in America is brought up to disown violence so consistently that its very presence in his own drawings can be adroitly (that is, innocently) denied. In the past few years, as I have worked with children in both southern rural slums and northern "ghettos," I have come to appreciate how useless it is to think of, or judge, the growth and development of the children of the depressed poor in the same way I ordinarily view the development of middle class children. It is, as one boy in a Boston ghetto recently reminded me, "a different ball game when you're out in left field, instead of in there pitching."

If we consider what a child of the slums goes through, from birth on, and if we keep a special eye on what in his experience may make him "violent" even at the age of 7 or 8, we may well gain, rather than lose, respect for the upbringing he receives. In fact, I have seen how much childbearing means to poor women: it is the one thing *they* can do, and do creatively. It is the one chance they have to show both themselves and others that there is hope in this world, as well as the next.

By pointing this out, I am not arguing against keeping families to a sensible size, nor overlooking the impulsive, dreary background that is also commonly associated with pregnancies among the poor, whether in or out of wedlock. I am simply saying to others what a mother once felt she had to let me know:

> They all tell us to cut down on the kids, cut down on the kids, because you can't keep up with them as it is, and even a few is too much if you're on welfare for life, the way we has to be, like it or not. I tries to cut down, and I want to, but it's not so easy. You have to watch your step all the time, and we can't afford the pills they have for others.
>
> Anyway, it's the one time in my life I really feel like I'm *somebody*, like I'm doing something. People come around and expect me to feel ashamed of myself, like I've done something wrong, and I'm adding to crime on the streets—that's all you hear these days, *our* crime, not anyone else's—but instead, I feel proud of myself, like I can at least make a baby, and maybe he'll have it better than us, who knows, though I doubt it.

If we want to help this woman keep her family small, I hope we also want to give her what she needs to feel like the somebody she still desires to be.

I know this woman's children, and already I have seen them readying themselves for what their mother herself calls "the goddam street." Each one of those children has been held and breast fed in ways I think some middle class mothers might have cause to envy. The flat is cold and rat infested, but there is real and continuing warmth between that mother and her babies. "Symbiotic" some of my colleagues—who have a name for everything—might call the relationship of that mother and her children; it is also a bond that unites the fearful and hungry against the inevitable day when the home has to yield to the outside.

Preparation for the street

Slum children do not go unprepared when that time comes, contrary to the assumptions of some social critics who can only see the life of the poor as aimless, neglected, and always "deprived." Chances are these children receive specific and brutal instruction about the "realities" of life at the age of 2, 3, or 4 so that when they emerge from the home the police, the hoods, the addicts, the drunks are already familiar, and what happens in the schools or on playgrounds is not disappointing but expected. The mother I have already quoted has also testified to the morality and lawfulness she tries to inspire in her children:

> I don't know how to do it. I don't know how to keep my kids from getting stained and ruined by everything outside. I keep them close to me, and sometimes I feel like everything will be O.K., because they know how much I want for it to be, and they'll go make it be, the way I thought I could. But after a while they want to go out. You know how a kid is when he's 3 or 4, he wants to *move*, no matter where, so long as he keeps going. And where can he move in here? So I let them go, and I stop and say a prayer every morning, and ask for them to be saved, but I have to say it, I'm not expecting my prayers to be answered, not around here, I know.
>
> And when the kids come back upstairs, I give them a look, if I have the time, to see what's on their face, and what they've learned that'll make a mess of everything I try to teach. And I can tell—I can tell from day to day what's getting into them. You know what it is? It's the Devil and he tells them to give up, because there's no other choice, not around here there isn't.

She is a churchgoing woman, as are many of her neighbors. I have found that she knows her Bible better than I or my neighbors, and in fact she doubtless puts more store in prophetic, messianic Christianity than most Americans do. When her children start walking and talking, she starts teaching them rules and fears—enough of both to satisfy anyone who is worried about the decline of "morality" in America.

At least in that home, and others like it I have visited, children are not allowed free reign. Instead they are told to obey, and they are swiftly slapped or punched if they falter.

Over the years I have learned how loyal slum families can be to America's ethic of "rugged individualism." Children are taught through the ubiquitous television to seek after all the products of our proud technology: the cars that can speed faster than any law allows; the records and clothes whose worth can only be seasonal; the bright and shiny places to frequent; the showy, gadget-filled places that not only shelter people but also make statements about their power, influence, and bank accounts. At 5 and 6 years old, ghetto children in today's America share through television a world quite similar to the one known by their wealthy age-mates. I find it almost unnerving when I see drawings from a child not yet old enough to attend school that show the appetites and yearnings our advertisers are able to arouse. Precisely what do such children do with such wishes and fantasies, besides spell them out on paper for someone like me?

In school

When a child of 6 or 7 from the ghetto meets up with the politics of the street or the schoolyard, he brings along both the sensual and the fearfully moral experience he has had at home. Slum children live at close quarters to their parents and their brothers or sisters. They are often allowed to be very much on their own, very free and active, yet they are also punished with a vengeance when distracted or forlorn parents suddenly find an issue forced, a confrontation inevitable. They face an ironic mixture of indulgence and fierce curtailment.

Such children come to school prepared to be active, vigorous, perhaps much more outgoing on an average than middle class children. But they are quick to lose patience, sulk, feel wrong and wronged and cheated by a world they have already learned to be impossible, uncertain, and contradictory. Here are the words of an elementary-school teacher who has worked in a northern ghetto for 3 years and still feels able to talk about the experience with hope as well as bitter irony:

They're hard to take these kids, because they're not what you think when you first come, but they're not what you'd like for them to be either. (I don't mean what I *used* to like for them to be, but what I want for them now.) They're fast and clever, and full of life. That was the hardest thing for me to realize—that a boy or girl in the ghetto isn't a hopeless case, or someone who is already a delinquent when he comes into the first grade. The misconceptions we have in the suburbs are fantastic, really, as I think back—and remember what I used to think myself.

I expected to find children who had given up, and were on the way to fail, or to take dope, or something like that. Instead it was in a lot of ways a breath of fresh air, talking with them and teaching them. They were friendlier, and they got along better with one another. I didn't have to spend half the year trying to encourage the children to be less competitive with one another. We don't call middle class children "culturally deprived," but sometimes I wonder. They're so nervous and worried about everything they say—what it will mean, or what it will cost them, or how it will be interpreted. That's what they've learned at home, and that's why a lot of them are tense kids, and, even worse, stale kids, with frowns on their faces at ages 6 or 7.

Not a lot of the kids I teach now. They're lively and active, so active I don't know how to keep up with them. They're not active learners, at least learners of the knowledge I'm trying to sell them, but they're active and they learn a lot about the world, about one another. In fact, one of the big adjustments I've had to make is realizing that these kids learn a lot from one another. They are smart about things my kids will never understand. They just don't think school is worth a damn. To them it's part of a big outside world that has a grip on them, and won't let them get any place, no matter how hard they try. So what's the use, they ask themselves; and the answer is that there isn't any use—so they go right on marking time in class until they can get out.

We teachers then figure they're stupid, or they're hopelessly tough and "delinquent," or their homes are so bad they'll always be "antisocial" or "incorrigible." I've found that when they're playing and don't know I'm looking they are different kids—spontaneous, shrewd, very smart, and perceptive. Then we go back into the classroom, and it's as though a dense fog has settled in on all of us. They give me a dazed look, or a stubborn, uncooperative one, and they just don't do anything, unless forced to—by being pushed and shoved and made to fear the authority they know I have.

We have compared notes many times, this teacher and I. One child we both know is a boy of 8 who does very poor work in school. He is a belligerent child, a troublemaker. I see him in his home because his brother is going to a predominantly white subur-

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Robert Coles, M.D., is a child psychiatrist on the research staff of the Harvard University Health Services. He has studied migrant farm children, Negro children who have spearheaded school desegregation in the South, and children in the North who are "bussed" from urban slums to suburban schools. His book, "Children of Crisis: A Study of Courage and Fear," is being published this May (Atlantic-Little Brown).

ban school, one of the very few children in the neighborhood who does. Their mother, living on public assistance with six children and no husband, has her hands full. She finds her "difficult child" smarter than her "model" one, the boy I watch riding a bus that takes him away from the ghetto.

The teacher and I agree, the "difficult boy" is a smart boy, but an impatient, agile, and provocative boy. He is headed for trouble, but as I talk with him I find *myself* in trouble. I have asked him to draw pictures—of himself, of his school, of his home, of anything he wishes. I get from him devastating portrayals: schools that look like jails; teachers whose faces show scorn or drowsiness; streets and homes that are as awful to see on paper as they are in real life; "outsiders" whose power and mercenary hostility are all too obvious; and, everywhere, the police, looking for trouble, creating trouble, checking up, hauling people to court, calling them names, getting ready to hurt them, assault them, jail them, and beat them up—even if they are children.

Once I asked the boy whether he *really* thought the police would hurt someone of his age. He said: "To the cops, everyone around here is a little bad boy, no matter how old he is or how many grandchildren he has around."

At moments like that my psychiatric, categorical mind finds itself stunned and for a change ready to grant that boy and others like him freedom from the various diagnostic, explanatory, or predictive schemes people like me learn so well and find to be (in our world) so useful.

An impossible situation

I often find welfare workers as well as the police present in the pictures ghetto children draw. They stand near the police like dogs, caricatures of themselves, with huge piercing eyes, ears that seem as twisted as they are oversize, and mouths either noticeably absent or present as thin lines enclosing prominent and decidedly pointed and ragged teeth. To ghetto children, as to their parents, the welfare worker is the policeman's handmaiden, and together they come, as one child put it, "to keep us in line, or send us away."

I have listened to public welfare workers and their "clients" talk, and I recognize the impossible situation they both face, the worker often as insulted as the family he visits by the rules and regulations they must contend with—and find a way around. I often compare the relationship between the workers and their clients with one that develops in psychotherapy as for a while powerful forces pull both doctor and patient backward in time toward those early years when parents check up on children, trying to keep them on the right side of a "line" that constantly puzzles the child and perhaps also the parent more than she or he realizes.

One welfare worker recently summarized the situation for me:

They behave like evasive kids, always trying to avoid getting caught, for this or that. And me, I'm like a child myself, only an older one—always trying to take care of my poor brothers and sisters, but also trying to get them in trouble or find them in trouble, so I can squeal on them.

No wonder I encounter anger, frustration, and violence in ghetto children. Everywhere things go wrong: the lights don't work; the stairs are treacherous; rats constantly appear, and they are not timid; uniformed men patrol the streets, certain that trouble will appear; teachers work in schools they are ashamed to call their own, at work they judge hopeless, under a bureaucratic system that stifles them, that is, if they are still alive; jobs are few, and "welfare" is the essence of the economy.

Yet—and I am writing this article chiefly to say so—the ghetto does not kill its young children. That perhaps comes later, at age 12 or 14, when idleness becomes a way of life, when jobs are nowhere to be had. For a while, during the first decade of their existence, ghetto children huddle together, learn about the world they have inherited, and go on to explore it, master its facts, accept its fate, and burn from day to day their inner energy and life, able for a while to ignore the alien outside world.

I find in these children a vitality, an exuberance, that reminds me often of the fatally ill I once treated on hospital wards: for a long time they appear flushed with life, even beautiful, only to die. I remember hearing from a distinguished physician who supervised a few of us who were interns: "They're fighting the battle of tuberculosis, and they're going to lose, but not without a brilliant flash of energy. It's a shame we can't intervene, right at the critical moment, and help them win."

He, of course, had the faith that some day medicine would intervene—with one or another saving treatment. Ghetto people have no such confidence, and I am afraid that I, at least today, share their outlook.

UNMARRIED MOTHERS—

the service gap revisited

ELIZABETH HERZOG

Very few flat and unchallengeable statements can be made about unmarried mothers and their children. One, however, seems immune to argument: during the past 25 years, the number of births out of wedlock has risen dramatically—from about 89,000 in 1940 to an estimated 291,000 in 1965. The "ratio" (the proportion of all live births that are births out of wedlock) has also risen. But what we hear about less often is that the overall "rate" (the number of births out of wedlock per 1,000 unmarried women of childbearing age) has remained relatively constant since 1957.

Those who are responsible for planning programs and giving services must be aware of *numbers*. Those who attempt to understand and interpret the nature and meaning of trends must be concerned with *rates*. And a study of rates tells us that, although many factors enter in, the chief reason for the recent increase in numbers of out-of-wedlock births is that there are more women of childbearing age today than in the past.

The reasoning behind these comments on numbers, ratios, and rates has been discussed elsewhere.[1-4] They are made here merely as background to the proposition that people concerned with helping unmarried mothers and their children can afford to relax their present anxious preoccupation with each new set of figures on out-of-wedlock births. We know that numbers have already outstripped services. The demographers tell us that numbers will probably continue to rise during the years just ahead, even if rates stand still or dip; and that this is chiefly because there will be more women of childbearing age.

Increasing numbers threaten to increase the gap between services and needs because practitioners of all kinds are unlikely to multiply as much as out-of-wedlock births. Moreover, our ideas about service expand far faster than does our manpower for carrying them out. For the next 10 years, then, no new statistics are needed to show that our utmost efforts may reduce, but cannot close, the service gap.

Some pertinent questions

Instead of questions about trends, three other questions seem more pertinent today:

1. What factors are associated with extramarital motherhood?

2. What services are needed by and helpful to unmarried mothers and their children?

3. What can be done to reduce the rate of out-of-wedlock births?

Space permits only a passing bow to two of these questions and a brief comment on the third.

With regard to the first, the salient point is that most of the imputed causes tend to dwindle when other relevant variables are carefully controlled. The factors that so far do not appear to stand up under analysis as *the* major cause include low intelligence, broken homes, geographical mobility, and psychological or interpersonal disturbances. Any

of these factors may be involved in specific instances, but none can be held mainly accountable for *the* problem.

A factor that so far does seem to stand up against challenge, not as *the* cause of unmarried motherhood but as a major factor associated with it, is economic status. When statistics are analyzed, economic status appears to account for a good deal of the higher incidence of out-of-wedlock births among nonwhite mothers than among white mothers in this country. Although a substantial proportion of out-of-wedlock births is not connected with poverty and social disadvantage, these factors do figure in the majority of cases.

The second pertinent question about the kinds of services needed breaks down into a number of subquestions. Two of these are: (*a*) Do the needed services reach those they are supposed to reach? (*b*) Do they help those they do reach?

With regard to the first subquestion, the answer for the United States at large is a resounding "No." A rough but educated estimate is that less than one-third of our unmarried mothers receive services from social agencies near the time of the child's birth, and fewer still receive them at other times.[2, 5]

Maternity homes in the country at large, according to recent figures, are equipped to serve less than 10 percent of the unmarried mothers.[6] True, some maternity homes are making valiant and imaginative efforts to expand their services—for example, by serving some girls as outpatients and some in their own homes and by allowing some to live in the maternity home and go out daily to jobs in the community. However, services are far from sufficient and those we do have are not distributed evenly or efficiently. A disproportionate amount of social services has gone to those unmarried mothers who are above the poverty line, who are white, and who are likely to place their children in adoption.[7, 8] In regard to health services the picture is somewhat different but also distressing.[9]

Strenuous efforts are being made to improve both the insufficiency and the imbalance of services to unmarried mothers, but we have a long, long way to go.

The second subquestion—how much are they helped?—is as painful as the first and much harder to answer. We do know that among the unmarried mothers reported as being served at all, a good many receive somewhat skimpy attention. Rather than dwell on the dark side, however, I would like to focus on one aspect of the effort to expand and improve services simultaneously. This is what appears to be an increasing determination to conquer the fragmentation from which services to unmarried mothers have suffered and to achieve service programs that are really comprehensive.

The reports of research and demonstration projects reviewed at the Children's Bureau, interim reports of projects still under way, and the applications received for support of new projects, as well as discussions by people who work with unmarried mothers, reflect a conviction that fragmentation of services should be combatted and that more comprehensive services should be developed. The effort is to coordinate, combine, integrate; to develop programs that bring together health, social, legal, economic, and, where appropriate, educational and vocational services into one integrated program. Many people believe that such integration will both expand and improve services and, by reducing duplication, will do so at less cost than would be required by separate services.

The patterns and the sponsorship of attempts at such integration vary, but the impulse toward it is strong and prevalent.

A few years ago, with the help of Rose Bernstein, the Children's Bureau undertook a systematic review of reports published before 1963 of research and demonstration projects concerned with unmarried mothers, including many community programs for extending and coordinating services. The following impressions, growing out of these and later projects, draw heavily on Mrs. Bernstein's analysis.

Comprehensive services

The efforts to develop comprehensive programs have been directed primarily toward three groups of unmarried mothers: (1) those who become known to hospitals and social agencies "too late" or not at all; (2) those who do not come into the purview of community medical and social agencies, making their medical plans privately and making independent arrangements for adoptive placements; (3) those who have need of special help to continue in school or to develop vocational skills.

One major value mentioned in nearly every report of efforts to coordinate services is the gain in interprofessional information and understanding. The various professions and disciplines learn about the functions, methods, and goals of others. They are amazed at what they did not know about others and what others did not know about them. Among the professional groups specifically mentioned in the re-

port of one of the largest, most enduring, and most carefully documented projects were social workers, doctors, hospital nurses, public health nurses, lawyers, clergymen, school officials and teachers, and policewomen.

Other reports also note that social agency staff members and hospital nurses become acquainted with the varied and effective assistance offered by the public health nurses, that doctors learn more about social workers and what they do. An obstetrician exclaims with pleasure that it is a boon to know, before a girl is actually sitting in his office, what the community's social agency resources are, what the State has to offer outside of the community, and what legal regulations he must be aware of in advising her about where to go. A social worker says, "I didn't realize how much the schoolteachers can help us!"

A corollary to increased information is likely to be closer and more effective working relations.

Closely related to increased information and more effective working relations in the reports reviewed are improvements in practices and policies for seeing that unmarried mothers get the services they need: the use of referral services; an increase in referrals from agencies and individual professional people (doctors, lawyers, clergymen, school personnel, and others); and greater followthrough in an effort to make sure that the referral results in an active contact.

Except in relation to a few continuing projects, it is not clear how long these effects last since followup reports on the projects are rare. Apparently, extended duration depends on continued efforts, and in many cases lack of staff, funds, and community support have resulted in a drifting back to the predemonstration status.

That understanding and cooperation between professions and disciplines are necessary to coordinate services goes without saying. The remarkable finding was that in so many communities it took a special project with outside funding to achieve this desirable result. It reminds me of my freshman Latin teacher in high school who had to teach us English grammar before he could teach us any Latin, because we had not learned about grammar in the elementary grades. By the end of the year, we did not know much Latin but we did know a little grammar.

The projects reviewed were completed several years ago, and it may be that by now the professions know more "grammar." Certainly efforts in this direction have been made, including some by the Children's Bureau in cooperation with the medical and legal professions.[10, 11] Last spring the American College of Obstetrics and Gynecology devoted a session at its annual meeting to an interprofessional discussion of unmarried mothers and their problems. Various other efforts to approach these problems interprofessionally are under way. One can only hope they will continue and will increase.

Some problems

Certain problems are repeatedly mentioned in the reports. One derives from success: greater efforts to bring unmarried mothers into service frequently succeed, and immediately the available facilities become overloaded. Few program planners seem to recognize the need to be prepared for more applicants if one launches a campaign to get them, and even fewer arrange to meet the response by enlarging the staff.

One result of suddenly increased caseloads can be the shutting down of intake. In one urban demonstration project, the pressure made it necessary to give service in a much larger number of cases than had been expected and therefore to limit it in many cases to brief contacts. These brief contacts tended to be in the poorest part of the city, where most of the women were Negroes. Pressure of caseload steered a large proportion of these unmarried mothers to an agency that already knew them, the public welfare agency—where they tended to get only the services they had received before, namely, financial assistance as indicated.

This particular report was completed before the 1962 amendments to the Social Security Act, which stress service in public welfare programs, could have an effect. Some of the imbalance in services is now being corrected through the effects of these amendments and subsequent developments. But the problem of too few services for too many people will be with us for a long time.

Elizabeth Herzog is chief of the child life studies branch, division of research, Children's Bureau. Before coming to the Bureau in 1954, she was director of research for the Jewish Family Service, New York. In various books and articles she has written both on anthropological subjects and on problems and research needs in the social welfare field.

The most pervasive and massive problem is demonstrated more often than stated in the reports: the administrative and personal difficulties of carrying out a determination to coordinate or integrate services. The need for centralized leadership is evident again and again, as is the fact that this kind of leadership is not always welcomed or accepted. Some projects apparently succeed in working out ways of integrating health and welfare and other services. Often, however, the problems are not fully solved and not fully faced. One hears by the grapevine of foot dragging by one department in a program set up under another's auspices.

For example, a project set up under a local department of health for helping pregnant unmarried teenage girls continue their schoolwork found that the education department assigned to the project its least qualified teachers. Only after prolonged effort was a better teaching staff mustered. Another project, set up under a local education department, traveled an unnecessarily thorny path to building in the desired social services. Occasionally, also, one hears of jurisdictional difficulties between two social agencies or two sources of health services, even though the final report presents a rosy, harmonious picture.

Even without interagency friction, a client sometimes falls between two agencies. In one study agency A had repeatedly reported that agency B was active in a case, but ultimately the investigator learned that agency B was not actively involved.

Paths to coordination

This does not mean to imply that collaboration is a poor idea, but rather that if the value is to be tested and the benefits reaped collaboration must really exist. It also means that the problems of coordination and collaboration must be recognized and faced sooner and more clearly than often happens.

To combine, to coordinate, or to integrate programs involves different kinds of processes. There are those who believe, with Alfred Kahn, that only a comprehensive and integrated network of services will meet the needs, and that this cannot be achieved by putting together a patchwork of already existing activities.[12] However this may be, in the immediate present many communities find it more feasible to attempt a welding of agencies and services already existing than to reorganize them entirely into a new multipurpose, multiservice organization. I have no prescription for success in such efforts. Each community that attempts to coordinate services will have to solve these problems in its own way according to its own circumstances.

A number of projects aimed at coordinating services have produced gratifying results, sometimes by coming to a workable administrative arrangement through trial and error. But a number have foundered through failing to establish a workable administrative setup in advance. The habit of emphasizing the positive in reports robs initiators of new programs of the opportunity to benefit as fully as they might from the lessons learned by others.

Some essentials

Three points especially have been brought home to me in reviewing project reports and proposals:

1. Although it may be desirable for some communities to set up new, multiservice programs, for others it will be more realistic to build on existing resources than to try to create a large, new network of services with an independent structure. A challenging imperative for the latter is to facilitate innovation within existing agencies and organizations, to open up inviting and feasible pathways to change.

2. Some kind of centralized administrative authority is essential. One of several possible ways to achieve this would be by an administrative agent—a director general—operating outside any constituent agency. That is, rather than selecting one of the cooperating agencies or departments to exercise final administrative authority, the cooperating group would designate a person to coordinate the activities of all. This person would need both program experience and administrative know-how. The experience might have been gained in one or more of the cooperating organizations, but for the duration of his appointment he would be outside any constituent agency.

One would hope this director general would not be an evangelist of any single administrative faith, be it group dynamics, management counseling, or Yoga, but would have some familiarity with the relevant principles that have been found useful in welding together diverse disciplines and people—drawing these principles from any field and any experience that have developed them.

3. Whatever administrative plan is set up must be worked out very carefully in advance, with realistic recognition of the kinds of problems that are inevita-

ble in such an undertaking. What and how serious these problems are probably cannot be learned from the printed page. Full anticipation can come partly from experience and partly from picking the brains of people who have struggled with them. Someone could render a real service by systematically interviewing people who have been on the administrative end and those who have been on the practice end of programs designed to offer comprehensive services to unmarried mothers, as well as people who have been involved in other types of comprehensive services.

Continuing services

Another impression left by our review was that, for the most part, services designed for "unmarried mothers" end when the women they serve become in fact unmarried mothers—that is, at or shortly after delivery. A few demonstration programs—an increasing number fortunately—do offer help to such women in taking on the role of a mother, in learning to manage a household, and, if necessary, in earning an income. But, for the most part, services still focus on the prenatal and immediate postnatal period.

If services are to be truly comprehensive, they will have to serve unmarried mothers for several years after they actually become mothers.

It would not be feasible or sensible to try to transplant the Scandinavian pattern of service into this country. Yet in developing a system more satisfactory than the one we have—if, indeed, it could be called a system—we might profit from the Scandinavian experience. In Denmark, for example, an unmarried mother is given help in finding adequate living quarters, day care for her child, and education or vocational training for herself, sometimes for several years. According to reports more than 90 percent of the mothers so helped eventually marry and, presumably, establish stable homes.[12] The rates of births out of wedlock in Denmark are reported to have decreased in recent years. Without assuming a cause-and-effect relationship, one can still say that apparently the kind of help that opens up a vista of stable family life and economic independence does not increase such rates.

Because of the often-expressed fear that effective help for unmarried mothers might encourage births out of wedlock, it should be recognized that in this country also the scant evidence we have is all in the other direction. We have supplied ourselves over the years with plenty of evidence that withholding services and support does not decrease such births. And the few relevant studies available show that giving services and support does not increase them. Births out of wedlock do appear to be increased, however, by programs that put a premium on fatherless homes by refusing aid to families containing an able-bodied man, regardless of his ability to support.

And what of prevention?

That last comment heads directly into the question I said I would skip: the question of prevention. And I will skip it, too, after explaining why.

We need to differentiate sharply between serving people who have problems and forestalling the problems. Service agencies should be able as well as eager to help those who have become pregnant out of wedlock and to help their children much more than at present. Possibly they can also reduce somewhat the frequency of repeated out-of-wedlock pregnancies. Some promising efforts in the latter direction are projects for helping teenage unmarried mothers to complete their high school education, for example, in Chicago, Detroit, and the District of Columbia.[13, 14]

Educational and vocational competence cannot be guaranteed to reduce "recidivism," but lack of these achievements can be almost guaranteed to promote it. Nevertheless, according to some very convincing analyses, out-of-wedlock pregnancy is largely the result of social and economic forces that service agencies cannot be expected to control or even to modify greatly.

Many people were disturbed by the study report, "Girls at Vocational High," [15] which concluded that social casework services did not substantially reduce school dropout, out-of-wedlock pregnancy, and other symptoms of undesired behavior among the girls who received the services. But how can we expect individual or group counseling to counteract the tremendous weight of social and economic deprivations burdening these particular girls? When young people have been as deprived as were those who predominated in the study group, perhaps the desired results can be hoped for only after a couple of generations have been reared with adequate employment opportunity, adequate social respect, and adequate self-esteem.

But even then, years of social and economic rehabilitation might only open the way for response to the influences that affect a very different group of

unmarried mothers—the white and nonpoor, among whom rates may have risen faster in recent years than among the first group. With regard to the socially advantaged, a different set of social forces appear to be operating.

To discuss prevention of unmarried parenthood at this time, one would have to discuss our economy, including the consequences of poverty for the poor and the consequences of affluence for the rest of us. One would also have to discuss the values we talk about and the values we live by, the discrepancies between them, and the impact on youth of those discrepancies. One would have to discuss the effects of social and economic discrimination on Negro men, women, children, and families. One would have to discuss the effects of affluence, our current life tempo, and the status-success-money-popularity complex on all our young people.

It is appropriate to discuss all these subjects and a number of related ones. But it is not appropriate to hold our helping services accountable—or for them to hold themselves accountable—for changing the values and behavior patterns that our society has fostered and continues to tolerate.

With regard to prevention, I should add that whether dissemination of information and resources for family planning will perceptibly affect illegitimacy rates in the near future is a question not easily or categorically answered, even by demographic experts. However, there is strong consensus among its advocates that the encouragement of family planning is likely to enhance the quality of family life and therefore to be beneficial to all family members, married or unmarried.

In summary

I have been trying to establish several points, the chief of which are:

1. The increase in births out of wedlock has occurred chiefly because there are more people and not because the likelihood has increased that an unmarried woman will bear a child out of wedlock.

2. Even if illegitimacy rates remain constant, or even if they decrease somewhat, the numbers can be expected to continue rising.

3. To the extent that increase in numbers exceeds increase in services, the longstanding service gap widens; and it also widens as our ideas broaden about the kinds of services that should be available to unmarried mothers and their children.

4. Efforts to coordinate and integrate different kinds of services represent a promising trend.

5. Such efforts have the best chance of success if they are preceded by concerted, extended, and realistic planning that takes account of the human and organizational problems involved in fusing the activities of separate, autonomous disciplines and organizations, and builds on the experience of others in similar undertakings.

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a guide for collaboration of PHYSICIAN, SOCIAL WORKER, and LAWYER in helping the UNMARRIED MOTHER and HER CHILD

Physicians, social workers, and lawyers are the professional persons who in their practice most frequently encounter unmarried mothers. Where does the responsibility of each begin and end and how can they most fruitfully work together to best serve the needs of the unmarried mother and her child?

For the past 5 years the organizations that represent these professions, led by the American College of Obstetricians and Gynecologists, have been working with the Children's Bureau and the Child Welfare League of America to formulate an answer to this question. The resulting statement, presented here, was completed in the summer of 1966 and by the end of the year had been officially approved by the following organizations:

The American College of Obstetricians and Gynecologists
The American Academy of Pediatrics
The American Medical Association
The American Bar Association, Section of Family Law
The Child Welfare League of America
The Children's Bureau.

The need for close cooperation between the physician, the social worker, and the lawyer in the care of the unmarried mother should be universally recognized. Each of these three is responsible for advising the unmarried mother of the need for consultation in her case with the other two disciplines involved, because each has a special field of competence. While recognizing that in some jurisdictions individuals, as such, may place or otherwise facilitate the adoption of minors, it should be emphasized, nonetheless, that physicians, social workers, and lawyers, individually or jointly, when acting as individuals and not in cooperation with a qualified child placement agency, do not have the facilities and resources necessary to provide protection and services needed by all persons affected by the adoption. To further this cooperation, the areas in which the primary responsibilities and those in which the function of the three disciplines overlap must be delineated.

The *physician* is held responsible for the physical and mental health of the patient. It is the physician who must make the diagnosis of pregnancy, determine the expected date of delivery, and decide where the delivery should take place. Among other things he must decide how much information the patient should be given on the physiology and pathology of pregnancy, labor, and the puerperium. His decision on whether to advise the patient to nurse the baby (if she decides to keep him) will rest on emotional as well as physical factors.

He must safeguard the confidentiality of the information the patient discloses except as provided by the laws of his State. Recognizing the limitations placed on a minor, he must be certain of the validity of the consent the patient gives for any disclosures, treatment, or procedure. If social services are available, the physician should avoid becoming involved with the placement of the infant or acting as an intermediary.

The responsibility of the *social worker* includes helping the unmarried mother with the distinctive social and emotional problems connected with having a child out of wedlock. To this end, the social worker draws upon the experience of social agencies in working with unmarried mothers, upon familiarity with community resources, and upon social and psychological diagnostic skills in determining what help a particular client needs and can use. Among

other things, this involves referring the patient for early and competent obstetrical examination, emphasizing the need for continued antepartal and postpartal care, reinforcing the medical care by strengthening the faith of the patient in the doctor, and, where possible or necessary, implementing his recommendations.

The social worker counsels the patient on plans for her future and that of the infant, always safeguarding the best interests of the child. The social worker provides psychological help and support complementing that given by the doctor. The social worker recognizes and supports the legal obligations of the doctor as to the results of treatment or advice, including professional disclosures and the peculiar problems of a minor.

The social worker counsels the unmarried mother in the various social aspects involved and recommends that she consult a lawyer for advice on the legal aspects as needed in the individual situation.

The *lawyer* for the unmarried mother is responsible for counseling her regarding the legal consequences of keeping or of giving up her child and of her legal rights in respect to the putative father. If she releases the child for adoption, he must be sure that all legal requirements are met. He should not represent the prospective adoptive parents. If social services are available, the lawyer should avoid becoming involved with the placement of the infant or acting as an intermediary.

All three disciplines recognize the right of the unmarried mother to make decisions for herself and her child except where such rights are involuntarily terminated by court action. Likewise, all three recognize that each must give advice and guidance to her. Whether giving advice is limited to mere clarification of the alternatives between which the client must choose or extends to a firm recommendation for the course of action the patient should take, the collective counseling, like parental guidance, must be harmonious lest the unmarried mother become confused. Differences of opinion which may arise as to the advice to be given should be resolved by prior conferences.

Broad principles have been established through experience in all three professions, but philosophies vary in different communities and change from time to time not only within the same community but also within the Nation.

Furthermore, each case must be individualized, particularly with reference to questions such as:

1. Shall the parent of the patient or the putative father be told of the pregnancy?

2. Shall the patient marry the putative father?

3. Shall legal action be taken against him?

4. Where shall delivery take place?

5. Shall the putative father visit the patient before or after delivery?

6. Shall he ever see the baby?

7. Shall the baby be photographed and the picture made available?

8. Shall the patient be allowed, urged, or forbidden to see her child, put him to breast, or care for him?

9. Shall the patient have psychiatric help; if so, to whom shall she be referred?

10. At which point in the pregnancy or puerperium shall the decision be made as to the child's future?

11. If the decision is for adoption, how and where shall final surrender of the child be taken?

12. Shall the mother be told of any deformity or handicap of the child and, if so, when and by whom?

13. If the matter of legal residence is involved and the possibility of nonadoptability, who shall be responsible for properly informing and counseling the unmarried mother?

When the doctor, social worker, and lawyer are mature, experienced individuals, each primarily concerned with working out the complex problems in any given case for the best interests of the child and the unmarried mother, each recognizing and respecting the responsibilities and competence of the other derived from professional training in dealing with the physical, mental, emotional, social, and legal factors involved, there rarely will be a difference of opinion. If such a difference does arise, one which cannot be resolved by a conference, genuine collaboration requires the wholehearted assistance of all three in supporting the judgment of the member of the discipline with primary responsibility, namely: for the physical and mental health of the mother and child, the doctor; for the social and emotional welfare of the mother and child, the social worker; and for the legal protection of the mother and the child, the lawyer.

SOCIAL WORK STUDENTS IN DAY-CARE SETTINGS

THELMA GOLDBERG

As day care is increasingly recognized as an essential child welfare service, it seems timely to examine the value of day-care settings for professional social work training. From the experience of a student unit that has been operating for the past 3 years in the Division of Day Care, New York City Department of Welfare (under a Children's Bureau grant to the New York University Graduate School of Social Work), I have been able to formulate some general principles about this type of fieldwork placement. Such principles must be general to be useful to social work educators planning fieldwork placements in day care, for day-care services are offered under many different kinds of auspices and embedded in a great variety of settings.

As the many types of services needed by culturally deprived preschool children are developed, the role of day care as a preventive child welfare service becomes clear. Too often child welfare services operate "after the fact": the family is already separated, and the focus is perforce on the child away from his natural family. Day care offers a rare opportunity for testing, in the observance rather than the breach, those child welfare principles that stress the importance of the child's own home. This focus on the family goes beyond the traditional appreciation in the field of early childhood education of the importance to the child of the parent and the home. The basic distinction between day-care services and nursery and other programs for preschool children is the focus in day care on the needs of the entire family and its economic, physical, and emotional burdens—a focus that may at times result in classroom groupings, hours of care, or other conditions not optimal for the child from an educational point of view.

What do we hope to prevent by offering day care for children? In extreme instances, we hope to prevent placement of children out of their own homes; in other instances, we hope to prevent subtler erosions and impoverishments of family life under social and psychological pressures. Here, surely, is a goal consistent with the basic ethics and values of professional social work.

However, evidence of social work thinking in the day-to-day operation of a day-care service is often sparse. In few instances has social work contributed its full share to the day-care center team in an integrated fashion. The profession is often represented by a single, overburdened worker who can rarely go beyond the demands of intake and emergency referral services. As in many child welfare settings, most social service staff members of day-care centers are not professionally trained. Only occasionally is there a sophisticated social work consultant available to staff members or parents even on a part-time basis.

In a fieldwork placement in a day-care center, this situation presents a problem for the students' supervisor, who must very actively serve as a professional model as well as a teacher and must continuously plan and intervene in the students' experiences in the centers. The paucity of the social work staff also means that sometimes new dimensions in service are being explored in the agency only by the students. Thus, special delicacy is called for in balancing service responsibilities and learning opportunities.

The supervisor must shape the student's caseload if the potentials for learning are to be tapped, but he can do this flexibly according to his own and his students' professional proclivities. For example, the day-care center provides opportunity, depending on the particular situation, to place more or less emphasis on the ways the center and its clients are

involved with the community, on work with parents' groups, on concentrated observation of the children and collaboration with the preschool teachers, or on casework with members of the child's family.

Uncovering needs

To the incoming social work student, the members of the center's educational staff may appear to be the backbone of the service; his first major task is to clarify his own role for himself, for them, and for the families being served.

Frequently, a family that needs help from the community in the care of its young children may be in need of other kinds of service as well. Yet, unless this comes out clearly at the time of intake, the parents may view the center as child oriented and "not interested in our other troubles," and the newly arrived social work students may be overly fearful of violating family privacy by offering service that has not been explicitly requested. But, as they come to feel more at home in the center and become more inventive in making themselves visible to the children's parents, the students uncover a wide range of needs and reactions. At one end of the range they find parents who are eager to avail themselves of social service and unable to get to an appropriate resource. For example, there was—

Mrs. M, a working mother with seven children, who had been seeking help with marital problems and also service for an acting-out, preadolescent child. Because of a complex schedule on her job and the lack of services in or near her neighborhood, she could not get the help she needed until a social work student at the day-care center offered to discuss her problems with her at the time when she came to pick up her children. She was one of the first persons to request regular casework appointments, and she used them productively throughout the year.

A variant of this help-seeking client is the isolated or fearful parent who finds casework help more palatable if it is made available in a familiar ego-supportive setting in a way that enables him to drift into it at his own pace. Many such parents begin with occasional, irregular appointments with the social worker and move on later to planned regular contacts; they may need to test the relationship with the social worker for comfort and viability.

At the other end of the range, the students find families who are not seeking service, actively or passively, but who obviously are beset with many problems, often including child neglect or abuse. These unmotivated, disorganized families in many ways resemble those found in a protective services caseload. With them the student is plunged into experimenting with the reaching-out, "aggressive casework" techniques that have been receiving increasing attention in social work. Their concern about violating the principles of self-determination and their desire to minimize and get beyond rejection make for considerable discussion and debate with each other and with their supervisor.

The students, however, tend to feel isolated if these issues are discussed only at the agency. "Catching" a caseload, defining one's professional role and goals, and thinking through one's basic philosophic stance are demanding experiences. More thought needs to be given in the schools of social work to ways of modifying the curriculum so that what students learn in the classroom will mesh more closely with the experiences they are having in this and other new types of fieldwork placements. Perhaps more use could be made of the case material as it is fed back into the schools.

As time goes on, the students do make many productive contacts with some of these "hard-to-reach" families and they find this a most rewarding experience. (Some students have found the experience a valuable foundation for later work in community psychiatry programs.) At times, too, because their caseloads are small, students can pick up on the less obviously critical needs of a family in crisis.

Mrs. P's young children had been brought to the day-care center when their mother, in a suicidal depression, had applied for admission to a mental hospital. The social work student observed that a 14-year-old daughter was taking on an increasing number of responsibilities and spending nearly all of her time with her mother. She seemed to be taking over the husband's role with the mother and the mother's role with the younger children, while unconsciously avoiding facing her own academic retardation and isolation from her peers. The social work student helped the father become more directly involved in planning; arranged for a temporary homemaker to go into the home; and offered the girl casework and tutorial services to enable her to pick up the threads of her own life again.

A unique opportunity

The day-care caseload, thus, is in some respects an educational smorgasbord. It offers students of social work some learning opportunities similar to those in the family, child welfare, and child guidance services, as well as the kind of learning opportunities found in authoritative or crisis-oriented settings. What does day care offer that is special and unique? An unparalleled opportunity to observe young children in depth and over a long period of time!

Many social work educators have long felt that the social work curriculum lacks sufficient content in child development and behavior and that the little that is taught in this regard is presented in a fashion that is almost exclusively theoretical. However, in a day-care center, social work students are intensively exposed to the young child in action, alone and in the group; they learn intimately the meaning of "ages and stages"; and they are confronted with the subtle ramifications of child-adult relationships. In such a setting they can observe at first hand the interactions between family members and the effect of familial, cultural, and class styles of child rearing on individual children.

A child's reaction to separation from his parents becomes much more than a textbook concept when one watches children newly admitted to the center, the last child to be picked up in the evening, or the mother who is herself fearful of leaving the support of the center as her child approaches school age. To see a 3-year-old child weep for mommy at nap time but turn his back on her in mock absorption with a toy when she comes for him in the evening; to watch a fatherless boy repeatedly play grownup in a man's hat; to notice a parent's mixed reactions to his child's growing mastery of a language he does not speak or his envy of the care the child receives; to see evidence of the insatiable yearning of a 4-year-old child in his clinging response to the teacher who takes him on her lap—each of these everyday experiences in a day-care center brings the real meaning of a theoretical concept home to the student.

At times the student may work directly with a group of children or an individual child in the center; he will not be in the position of talking to a parent whose child he has never seen. This aspect of the placement, combined with more frequent home visiting than is usual in other types of fieldwork placement, makes for a three dimensional view of family life. With this perspective, the student can more readily recognize the effect of special circumstances. For example:

Mr. L applied for day care for his 5-year-old child after the sudden death of his wife. He had not told the boy of the death and felt the child was little disturbed by it. However, the social work student noticed that in the classroom the child showed increasing preoccupation with fantasies of destruction and disappearance; signs of depression; phobic clinging to a motherly teacher; and "irrational" expressions of rage against the father.

* * *

Mrs. S complained that the hospital treating her son for a mild case of cerebral palsy had decided that, despite his excellent adjustment to the day-care center program, he could not enter a regular first-grade class because of a speech handicap. Watching this child in the group, the student saw signs of unusual compensatory devices in him. He was extremely cheerful and outgoing, reached for help as he needed it, ignored rebuffs and teasing, managed to communicate despite his speech problems. Therefore, the school guidance counselor was invited to observe the child at the center and to evaluate his functioning. As a result, the school admitted the child to a regular class.

Teacher and social worker

In any day-care service, a large percentage of referrals for social service directly involve the well-being of children in the center. Teachers naturally try to speak to the parents directly about the things that worry them, often in an effort to help parents modify their handling of the child. But many parents are so emotionally deprived themselves that they themselves must be "fed" before they can feed their children; their own worth must be affirmed; they, too, must be helped to have fun. Some parents see young children as extensions of themselves and so cannot mobilize their parental strength unless their own patterns of functioning and their own individuality are recognized. Fortunately, in most day-care centers I have known, staff acceptance for parents is genuine, and fruitful collaboration between teacher and social worker takes place.

Mrs. Z was referred to the student social worker by the teacher because she seemed unable to pick up her children on time or to feed and clothe them appropriately. Mrs. Z was a 24-year-old divorcee with four children. She was described by the teacher as gay and impulsive, unable to control the children, "a big kid herself." She had been known earlier to a family agency, which had "talked her out of placing the children."

In her interviews with the student, Mrs. Z quickly revealed, under her gay façade, feelings of depression and worthlessness, a sense that no one cared for her except as the mother of her children. As the teachers and director continued to point out to Mrs. Z her maternal responsibilities, the student focused Mrs. Z's attention on her own needs and aspirations

Thelma Goldberg is an assistant professor at the Graduate School of Social Work, New York University. Prior to her present position, she was the university's social work field instructor who set up the day-care student unit reported on in this article. Her previous experience includes work in family service agencies, child guidance clinics, and a residential treatment center. She has also served as a social work consultant to the staffs of nursery schools and day-care centers.

and helped her look into the reasons why she needed to invite social disapproval. When the student's fieldwork placement in the center ended, Mrs. Z accepted referral to another agency for continuing casework service. Said she: "I needed a social worker to chase me."

Mrs. Z's case illustrates the value of spelling out the differences in the roles of the teacher and the social worker in relation to a particular client. Collaboration is possible only when each party understands the special contribution of the other and the effectiveness of each is enhanced by a team approach. Learning what teachers can offer and how to communicate with them in the best interests of children and families is an important part of the social work education that takes place in a day-care setting and one that will be useful to the student in future professional functioning.

Finally, a word must be said about two important aspects of the social work process that students can learn to master in a day-care setting: (1) the appropriate application of diagnostic thinking; and (2) inventiveness in the use of social resources, including one's own agency. In a day-care center these processes are clearest in the period of intake study and in the "reviews" to determine what use is being made of the service.

Miss J applied for day-care service for her 3-year-old daughter, who had been born out of wedlock. The child was exhibiting bizarre traits in speech and character and seemed to be reacting to an extremely confused pattern of living. A careful intake study produced a great deal of evidence that Miss J was psychotic and very much afraid of being referred for psychiatric help. She had ambivalent feelings about having applied for day care, for she was afraid both of being scrutinized by other people and being separated from her child.

It was decided to try to support Miss J by admitting the child to the center and so exposing her to some healthy influences. Upon admission, the little girl proved to be not too damaged to respond to staff members and to the other children and quickly made great developmental strides. The student helped the staff understand the mother's condition so that demands in excess of her ability were not placed on her.

* * *

Mrs. W applied for day care for her two children on the basis of her need to work to supplement her husband's income. Soon after the children's admittance, however, she lost her job and for a while thereafter seemed to be avoiding the members of the center's staff. The teachers suspected that she was being punitive toward the youngest child, who at the same time was being overindulged by his father. The student arranged for an interview with Mrs. W and told her that her loss of employment did not affect her eligibility for the center's services. Mrs. W appeared relieved; she indicated that she was preoccupied with a serious marital conflict she did not wish to discuss and that she wanted her children to remain at the center primarily to protect them from her own stormy feelings. Eventually Mrs. W asked for counseling service to work out plans for herself and the children following a long-threatened separation from her husband.

What can be distilled as the essence of a student's experience in day care as compared to fieldwork placements in other settings? Certainly the fact that the student obtains entrée to the family by means of involvement with their young children affects the quality of the experience. As we have seen in such a setting, parents may initially be reluctant to discuss their negative feelings toward a child or may need to test the genuineness of the agency's interest in themselves and their older children. However, most families seem to approach the day-care center in an aura of hopefulness, as though the opportunity to send a young child into the larger community for the first time were providing them with a second chance. This hopefulness, coupled with the relief from stress the concrete service provides them, may make them more accessible to social work intervention on many seemingly unrelated levels of experience. For the same reason, families whose children are no longer in a day-care center may return to the center in times of trouble; it tends to be invested for them with the feeling that a fresh start may be possible.

I think there are two crucial ways in which social work students are touched by an experience in a day-care center. The first comes from operating in a setting in which their profession is in the minority. To function, they are forced to examine and to articulate, in a direct and personal way, what it means to be a social worker, how a person goes about being one when his service has not been requested by the client, and how he explains what he does to his colleagues from another discipline.

The second crucial way in which social work students are touched by an experience in a day-care center can be observed in how they react to a children's shelter or a foster home program or to a theoretical discussion of children's needs. Whatever their own backgrounds and preconceptions, regardless of their particular caseloads, the social work students in day care unanimously seem to have a deep and burning conviction of the irreplaceability of the child's own family, flawed and idiosyncratic though it may be, for the young child. In these times when the importance of his own family to the child often seems mentioned only as a half-hearted cliché, ignored in program planning, an experience that brings it home so vividly to social workers at the start of their careers would seem to merit a place in professional education.

A GROUPWORK APPROACH IN CROSS-CULTURAL ADOPTIONS

CONSTANCE RATHBUN ● RALPH L. KOLODNY

"The love and attention of two new parents and the influence of many playmates here in Massachusetts are turning an active little Chinese girl into an active American."

In these terms a Boston newspaper describes the adoption by a Caucasian couple in New England of a child from an orphanage in Hong Kong. Behind this statement are a series of problems in interracial adoptions, often thought about by social workers but only infrequently subjected to careful scrutiny. From the perspective of the community, the experience may be regarded as a "humanitarian adventure" in which there is much sincere interest. From the adoptive parents' perspective, however, it represents a procedure that poses a host of dilemmas.

Of primary significance in the creation of these dilemmas is the shift in the adopted child's role from that of one child among many similar children in an institutional setting overseen by one woman to that of a child in a family with her own father, mother, and brothers and sisters. Of equal importance is the radical change from ancient Chinese to contemporary American rules of conduct. These transitions, moreover, have to be made by the child in a society ambivalent toward racial mixture. The child's adoptive parents are in the unique position of having to prepare their oriental child for the status accorded a member of a minority group while simultaneously attempting to help him become emotionally a part of a family that is part of the dominant majority.

These special child-rearing problems apparently do not immobilize most of the adoptive parents. What followup reports we have of this type of adoption in most cases do not suggest severely pathological adaptations either in the child or the family.[1] One can assume, however, that such problems engender tensions that must be expressed and dealt with if the adoption is to be a really positive experience for all concerned.

The kinds of tensions that arise in such families and the kinds of problems that worry the adoptive parents have been brought out clearly in the group meetings of five sets of adoptive parents of five preadolescent Chinese girls who came to this country from the same orphanage in Hong Kong and were placed for adoption by the Boston Children's Service Association. All of these parents had children by birth as well as by adoption and had been the subjects of a home study and casework service before the adoptions became legal.

The discussion group was initiated shortly after the children's placement and continued for many months after the adoption decrees had been granted. It was formed and led by Carol A. Jenkinson, a member of the agency's groupwork staff who met with the group at the agency's office for more than 2 years. During this period, the group held ten 2-hour sessions, the rather wide spacing of meetings having been dictated by problems of distance and New England winter weather.

Age-related problems

One would, of course, expect parents of girls on the threshold of adolescence when meeting together to discuss their perplexities about this stage of development and their methods of coping with its crises. Our group was no exception. The parents expressed concern about ways of dealing with the normal nega-

tivism of this stage, about ways of helping a girl accept a more feminine role without encouraging her to act out sexually, and about methods of preparing a preadolescent girl for menstruation. These issues came up early in the group's existence and continued to appear, disappear, and reappear with varying intensity. As they discussed such subjects, the group sometimes sounded like any other group of parents of pubescent children.

A major task of preadolescence is the transition from the sexually latent orientation of the preadolescent years to a clearer heterosexual identity. This appeared as a theme in an early meeting.

Mr. J turned to Mr. W to say how much Bunnie and his son had liked Jill. His son particularly had talked about nothing else except Jill ever since she'd been there. Mr. W said Jill made a hit with the boys as a "boy" still, and not yet as a girl. Mrs. J said she thought Jill had shown a bit more interest in clothes than she had the last time she'd seen her. Mrs. W said she guessed that Jill really was all girl but that right now it still seemed as though she wanted most to be a boy. Mrs. W said she hadn't given up hope, however, that Jill would soon develop into a girl as her shape was already changing and there were lots of other signs of her growing up.

Thus, the group as a kind of "affective forum" freed the parents to express their concern about the many facets of preadolescent sexuality that might otherwise have not only been concealed from others but also from themselves. The many reactions to the issues discussed provided each parent with a perspective within which he could begin to assess his own reactions differently. In the meetings any attempt by any set of parents to cope imaginatively with the problems of their youngsters generally received support from the group.

Impact of cultural duality

However, the normal growing up problems of these children were not the problems that monopolized the group's attention. Whatever their temporary confusion over how to respond to problems of emerging sexuality and independence, these parents obviously felt confident of their capacity for helping the children weather the normal stresses of this stage of development. Their greatest concern has been over the implications of the children's dual cultural heritage and their "different" racial background.

In talking about the children's transition from group life in China to family life in America, the parents at first stressed only how smooth this had been and how skilled the agency had been in determining which child should be placed in which adoptive home. They admitted the children had experienced some difficulties in respect to language and food, but said these had soon disappeared. At the first meeting the J's, for example, could not get over "how well Bunnie had been matched to them"—happy and loving, she trusted everyone. The other parents nodded affirmatively.

Both Constance Rathbun, left, and Ralph L. Kolodny were on the staff of the Boston Children's Service Association when the observations reported in this article were made, Miss Rathbun as director of casework and Mr. Kolodny as director of groupwork. Miss Rathbun is presently director of research and special instructor at the Simmons College School of Social Work, and Mr. Kolodny is associate professor at the Boston University School of Social Work.

At the second meeting, however, some of the anxieties that had been so carefully hidden when the group members first met each other began to emerge. They were expressed guardedly, but still with a great deal of feeling. The children, said the parents, had been displaying some ambivalence about their new names. The parents found this disconcerting, but were more worried about the fact that when under stress some of the children occasionally would go into a kind of hypnotic state. For example, the O's daughter, Lo Ming, had responded with extreme withdrawal when Mrs. O had taken a cake to her class at school. Jill had reacted in a similar way when she had suddenly hurt herself. The parents of these children felt helpless in not knowing how to reach either child in this "trancelike" state.

Later on in the meeting, the group talked about the fact that each child had had to find her own way of adapting herself to the institution in Hong Kong and now was having to readapt herself to an American family. The group worker pointed out that Mr. E had spoken in their previous meeting of his feeling that Nancy had to be almost too good in order to feel that they would accept her. Mrs. W said that maybe this was true of Jill who, in a way, also had to be too good. The questions then arose as to how secure the girls did feel and how confused they might be. The girls had visited at each other's homes at Christmas time, and now each of them was

calling all of the men "Daddy." This confused response occasioned considerable distress on the part of the "daddies," and led all of the parents to question whether the children would ever separate emotionally from their "family of origin"—the orphanage "family" in Hong Kong.

The worker wondered if the children even knew what it meant to have a family—to be a part of a small family with a mother and a father and with only a few siblings. Mrs. E said immediately and emphatically that she did not feel they understood this at all and that she and her husband felt their task was to educate their daughter to what a family was.

Mr. O said that Lo Ming may be a little bit more aware than the other children that she now had a family of her own. However, both he and Mrs. O said that they had to tell Lo Ming over and over again, in no uncertain terms, that they were her parents and that she was there to stay with them.

The group agreed that probably all of these children still had tremendous fears about whether or not they were really here to stay, and that it was pretty frightening to the youngsters to have a close relationship with parent figures now, particularly with a father. Mr. O said that Lo Ming had spoken of her father before she came to America as being "Jesus" and now she had two fathers—Jesus and Mr. O. Mr. E said he was sure that Nancy did not really know what a father was. He said he was really puzzled about whether or not he could educate her to understand what a family really was, and he wondered whether or not any of the children would ever really be able to become the adoptive parents' "own."

This was the first time that we had indications in the group of the feeling the parents might have about whether or not they ever could accept themselves as parents of these children or the children accept them as their parents. Mr. W said that probably the children never would be the same as their own children for, after all, their own children were white and these children were oriental.

Having found that the agency worker was not upset by their confusion and tension, the parents began to wrestle with the issue of how to help the children become "their own" without completely sacrificing the children's previous identity. They spoke of the role of the Chinese language in the children's present life. This led to some questions: Should or should not the parents search for a Chinese tutor to help the children keep up their Chinese? Should they take the children on visits to the parents' Chinese friends or not? If they did, would it demonstrate to the children how much they could love little Chinese girls? (Lo Ming had given some indication of feeling she could not be loved because she was Chinese.) What should they do if the child rejected reminders of her Chinese heritage? Do most of the schoolmates of these children regard them as potential companions or as mysterious "racial strangers" to be kept out of their peer groups? Does the behavior of schoolteachers toward the children reflect real acceptance?

As they looked more directly at the tension under which their adopted daughters were functioning, the parents began to discuss their confused ideas and negative feelings about the social milieu in which the girls had lived in Hong Kong. They told about puzzling reports from the children of some "sexual events" in the orphanage. It was difficult to determine what had stemmed from the children's very vivid imaginations and what had actually happened. The parents had at first been impressed by the sheltered nature of the children's life in an institution run by an all-powerful "mama." Now, having listened more closely to what the children were saying, they began to wonder whether sexual sophistication rather than naiveté had characterized their pre-American life.

Mrs. O, recounting a story Lo Ming had told her, wondered if the other families had heard about the "accident" that had taken place somewhere in Hong Kong, something involving a man and a woman in the nude. . . . Mr. and Mrs. W looked at each other with knowing eyes. . . .

It seems that Jill, the W's adopted child, at one time became very upset and told them she had had a bad dream. She had then referred to an experience in Hong Kong where some boy, and it was not clear who this was—whether the gardner, someone else, or a mythical person—had actually come to her room when she was in her bunk and had told her to take down her pants. She had become very much upset about this and had evidently screamed.

There was a question, as we looked at this, as to how much of the tale was real and how much of it was based on the fears and questions of a girl who knew too little about sex. The parents expressed some question as to how naive their children really were and said that they really did not know what had precipitated this type of story.

Facing marginality

Whatever their feelings of confusion and, perhaps, dismay over the possibility of their adopted daughters having had sexual encounters of some sort in Hong Kong and their concern about what this might mean in relation to their future behavior, the parents were now ready to consider the less "rosy" aspects of their relationships with the girls. In the group they apparently derived enough support from each other to bring into the open still more worries and areas of confusion. They now began to talk about the implications of the girls' racial "difference" for their heterosexual and general social relationships. Either the parents had not thought about this ques-

tion previously or had been blocked by anxiety from freely discussing it. By their sixth meeting, however, they were showing openly—though some at the same time denied it—their worry over the social marginality of these children and their fears lest the girls be left suspended in a kind of sociocultural limbo.

Mr. W said he worried about what would happen to his adopted daughter if war with China should occur. Mrs. J said, "I'll cross that bridge when I come to it," but she expressed unhappiness about the more immediate experience of seeing people stare at her daughter in restaurants. Mr. W said the hard thing to take is the fact that the children are not really accepted by the Chinese community here. "The Chinese don't like it at all because we have adopted their children." Mr. J said he and Mrs. J had not had any experience that gave them such an impression, and Mrs. A said that she had not either. Mr. W said he and his family had felt a kind of coldness when they went to a Chinese restaurant or to Chinatown and that some Chinese people had told him that they did not see why white people would want to adopt Chiese children and doubted whether the children could really be Chinese anymore.

Mrs. J said she had thought about enrolling Bunnie in a Chinese school so that she could keep some of her Chinese cultural background, but Mr. W said that the school would probably not accept Bunnie because she did not live in a Chinese family.

When Mrs. J asked the worker whether she thought the Chinese school would accept Bunnie, the worker replied that she did not know and then asked Mrs. J why she wanted to have Bunnie continue with Chinese. Mrs. J replied that she did not want Bunnie to lose her cultural heritage, but added suddenly, "But you know Bunnie seems more English than Chinese" because the orphanage "mama" had brought the children up that way. She said she did not know what would be best for Bunnie, but she felt that Bunnie would become all American eventually. . . .

Mrs. J then said that Bunnie had often spoken to her of the fact that she had three mothers—her own mother, the orphanage "mama," and now Mrs. J. She did not feel that Bunnie was at all confused about which mother was which and about what her relationship had been with each. She felt, however, that Bunnie was curious about her background and should be helped to know more about it.

Mrs. A said that her adopted daughter, Cathy, occasionally asked whether she could grow up to look like her "mummy" and to be an American. Mrs. A said she always told Cathy that she was a very pretty little girl and would grow up to be a very pretty Chinese lady.

Mrs. W said that she usually forgot that her two adopted daughters were Chinese, for they seemed so American to her in all of their ways. Her husband agreed but added that they did worry sometimes, especially about what would happen when the girls reached dating age. . . .

Each parent advanced his own notions of how to cope with these problems. The worker did not press them for consensus as to the best way of coping, but helped them provide each other with a series of alternatives that could be adapted to the particular circumstances of each child.

The J's eventually made the decision to send their child, Bunnie, to an afterhours Chinese school. The other parents then questioned them eagerly about Bunnie's experience there. The J's main purpose in sending the child there was to help her "realize the good parts of her Chinese background." Bunnie's major investment in going was more personal—this was a wish to keep the tie to her Chinese sisters in Hong Kong and to deepen her friendship with the Chinese minister's son, who is a fellow student. She enjoyed the school and, in contrast to her earlier position at home, was willing to be called by her Chinese name there, since all the students had both a Chinese and an English name.

Not all of the parents saw the Chinese school as a solution to the integration of the children's disparate strands of cultural influence. And they all still wrestled with the basic question: the degree to which these children would forever be Chinese. This came out in references to the children's appearance as they grew older. Would they be just "pretty ladies" or "pretty Chinese ladies"? "Would they be able to marry whomever they loved, regardless of race, or could a happy marriage result only if the alliance were with another Chinese?"

Disguised racial hostility

The parents exhibited a remarkable degree of frankness in their discusion of these questions. Then the latent and previously quite repressed racial hostility of one set of parents found expression in rationalized form.

Mr. and Mrs. A went on to give examples of the ways in which they were reminding their daughter that she is Chinese. Mrs. A said that unconsciously people used rather derogatory remarks about Chinese people in general conversations. They were sure their daughter would run into this as she grew older. They felt they owed it to her to prepare her for this, so that when she grew up she would not think people would just be mean to her but she would understand that some seemingly hostile remarks were just casual conversational idioms—just as when people say "that's Greek to me" when they cannot understand something.

Mr. A then said, "Yes, like people say 'crazy as a Chinaman,' or use the term 'chink' quite often." Mrs. A said they frequently use such phrases themselves around the house so that their daughter would know first that they could be made by people who loved you and were not meant to be derogatory. . . . Mrs. A again spoke up saying she was sure that her

daughter understood why they did it. Mr. A told of how he unconsciously had made some remarks about Chinese people to a group of young people in church and then had suddenly realized what he had said and looked at his son who was present and realized that he, too, was very conscious of the *faux pas* his father had made.

Many of the anxieties evidenced by these couples, as we have seen, were similar to those that might be felt by any parents who adopt older children. One would expect dating and marriage, for example, to be in the forefront of much of the discussion. However, such worries took on a somewhat more urgent character than usual among these parents. As do all couples who adopt older children, these couples were trying to follow two somewhat contradictory paths simultaneously—to find ways to help the children achieve a satisfying integration into their own family patterns and to prepare them for the adolescent's task of separating from a family not yet wholly theirs. The separation, however, was having to be accomplished in a social climate that made the parents unsure of the future attitudes of the community toward the children because of their ethnic origin.

Method and effects

The members did not receive advice from the group worker, nor from each other, on how to deal with these issues. Such issues will, no doubt, continue to trouble them in varying degrees as time goes on. Nor did the groupworker explore with the members any of the unconscious sources of their feelings about the issues they were concerned about or attempt to induce insight into the deeper veins of ambivalence that are always present in interracial adoption.

Rather, the groupworker helped each member to listen to the other and, in so doing, to listen to himself and thus to face honestly the problems bothering him. She gently countered the parents' tendency to deny the existence of such problems by conveying to them her feeling that the problems could be managed and a viable parent-child relationship created; that, while this relationship might be "strange" in some respects and at times not without some unpleasant components, it could be nurtured and bring increasing gratification; that fears and tensions need not be covered up in the interests of preserving family harmony; and that expressing and considering them in a group of persons in a similar situation could help strengthen the foundation of such harmony.

It is difficult to describe precisely the effects of this group experience on these adoptive parents. In the beginning we did not ourselves have any completely formulated notion of how they should use the group, although we were convinced that it would give support to their attempts at effective parenting. However, we do have evidence that their feelings toward the agency and toward their role as clients of the agency changed as a result of their participation in the group.

Initially the group members saw themselves as contributors to the agency, helping with its research into the workings of interracial adoption. Although based in fact, this attitude contained an element of defense against exposing themselves. Very soon it became clear that the parents were beginning to perceive the meetings as a means of supporting each other's efforts to cope with the many problems of adjustment they and the children were facing. No longer did each couple feel alone in struggling with a unique dilemma. To be able to talk about their anxieties with each other, with the catalytic help of the groupworker, gave them a healthier perspective from which to approach the task of building a stable family unit.

Testimonials by group participants are always slender reeds upon which to lean for evaluation, yet we cannot help but assign some degree of validity to them. The following entry in the record of the group's 10th meeting gives an example of a participant's own feeling about the group.

Mrs. J said she'd like to talk about something else. She had met another family who had adopted a Chinese child and this family envied them for having a group. . . . She thought all adoptive parents should be in a group with other parents, at least the first year they have the children. The others agreed this would be helpful. The worker asked why they felt this way. Mr. J said, "You think you are the only one with problems in the beginning and you are not so sure you ought to admit them even to yourself, but when you know others feel the same way it helps."

Only a later followup will test our interpretations of the meaning of this experience to these parents. We do know, however, that in the midst of their dilemmas and, possibly, second thoughts about the interracial adoptions in which they have involved themselves, these parents genuinely feel they have been helped by the group experience.

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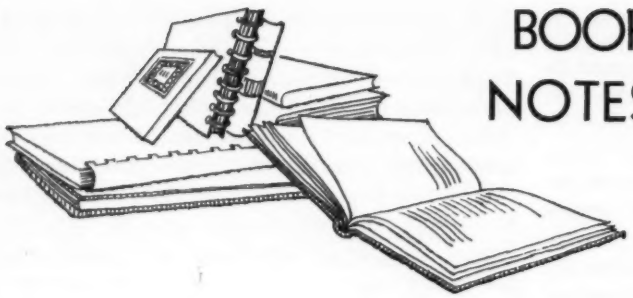
[1] Rathbun, C.; Bennett, C.; McLaughlin, H.; Garland, J. A.: Later adjustment of children following radical separation from family and culture. *American Journal of Orthopsychiatry*, April 1965.



BOOK NOTES

THE EMPTY FORTRESS: infantile autism and the birth of the self. Bruno Bettelheim. The Free Press, New York. 1967. 484 pp. $9.95.

Many childhood psychoses, particularly infantile autism, can be traced to the child's conviction that his life is in mortal danger, according to the author of this study of infantile autism. He maintains that autism results from a breakdown in communication between the infant and others caused by overwhelming anxiety: the child reacts to a seeming threat to his life by not acting at all.

From the findings of 20 years of work with several hundred children at the University of Chicago Orthogenic School, the author describes specific childhood aberrations, the development and distortion of the personality in infancy, and the progress of therapy with the autistic child. He includes three detailed case histories of extremely autistic children.

The author also takes up the subject of the feral child and argues from illustration that "wolf children" are probably autistic. In the book's final section, he discusses the findings and opinions of other psychiatrists and psychologists on the nature and origin of infantile autism.

DELINQUENT CHILDREN IN JUVENILE CORRECTIONAL INSTITUTIONS: State administered reception and diagnostic centers. Compiled and edited by William E. Amos and Raymond L. Manella. Foreword by James W. Symington. Charles C Thomas, Springfield, Ill. 1966. 159 pp. $7.50.

Through 10 experts in the correctional field, this book describes the resources and services of the reception and diagnostic centers for delinquent children 12 States were operating in March 1965. The contributors discuss the history and philosophy of the centers; their use of psychiatry, psychology, and social work in diagnosing each child's problems; the contribution of teachers, researchers, and court officials to the work of the centers; and the design of the physical plants.

The editors point out that the success of the centers depends on interprofessional teamwork. They maintain that State governments must take the lead in combating delinquency because city and county governments cannot provide the statewide facilities, services, and programs needed. And they express a strong belief in the need for reception and diagnostic centers and in their potential for helping control juvenile delinquency.

FERTILITY AND FAMILY PLANNING IN THE UNITED STATES. Pascal K. Whelpton, Arthur A. Campbell, and John E. Patterson. Princeton University Press, Princeton, N.J. 1966. 443 pp. $12.50.

About 92 percent of the 3,322 wives involved in the 1960 study of birth expectations and family planning on which this book reports said that they and their husbands wanted from 2 to 4 children and that they preferred to have them early in marriage. Though many couples planned to delay the use of contraceptives until their families were "complete," 87 percent of the wives said they had used or planned to use contraceptives at some time. Despite the delay in use by many couples, the authors found the number of couples who used contraceptives was much higher in 1960 than it had been in 1955, when they had made a similar study.

Education, socioeconomic status, religion, and race made a difference in the number of children the wives expected to have, the authors point out. Those with little education, in low-income groups, or who were Roman Catholics expected to have more children than others. Within the Catholic group, however, those in middle income groups expected to have fewer children than those in the lower and upper income groups. Nonwhite wives in the South expected to have more children than white wives, a difference not indicated in other regions.

The authors also discuss the wives' responses to questions about such subjects as fecundity impairment, methods and effectiveness of contraceptives, and the timing and spacing of births.

CULTURE IN AMERICAN EDUCATION: anthropological approaches to minority and dominant groups in the schools. Ruth Landes. John Wiley & Sons, New York. 1965. 330 pp. $7.95.

This book reports on a project conducted by the Claremont Graduate School, Claremont, Calif., from 1959 to 1961 under the direction of the author, a cultural anthropologist. This project brought together education, social work, and anthropology to help teachers find ways of meeting the needs of children from backgrounds "different" from those of most American children.

During the experiment, teachers and school social workers from public schools in the area were shown how to adapt their methods and to adjust their goals to differences in the cultural backgrounds of children from such minority groups as Mexican Americans and Negroes, the author points out. The teachers were led to see how group customs "channel human energy" and how to tap this energy in teaching. In time, the teachers came to realize that mental gifts and social inheritance should be placed above "physical or racial semblances," and the social workers found new ways of working out each case, the author maintains.

The Claremont project demonstrated the value of bringing the three fields together to improve education for the children of minority groups, the author also maintains, and she stresses the importance of using cultural patterns to attain the ends of education. Folkways "may yield to our mechanized age

and universal literacy . . . but principles of cultural existence will persist," she concludes.

PSYCHOLOGY IN COMMUNITY SETTINGS: clinical, educational, vocational, social aspects. Seymour B. Sarason, Murray Levine, I. Ira Goldenberg, Dennis L. Cherlin, and Edward M. Bennett. John Wiley & Sons, New York. 1966. 714 pp. $12.95.

Written by staff members of the Psycho-Educational Clinic at Yale University, this book describes the activities of the clinic in four New Haven (Conn.) settings—the elementary school system, the local community action program, a mental retardation center, and the clinic itself. It also explores the many problems faced by the schools in trying to help underprivileged children, gives illustrations of work in the school and the community, and describes the methods used in the clinic in day-by-day activities.

The authors' concluding point is that service to the community now requires a new type of worker—one trained to see cultural anthropology, sociology, psychology, and psychiatry as one field of knowledge, theory, and method. The problem is "how to introduce change into ongoing social systems. The solution will . . . depend on how well we understand these social systems in their terms."

THE CAMP PHYSICIAN'S MANUAL. David Goldring, M.D. Charles C Thomas, Springfield, Ill. 1967. 168 pp. $8.50.

Written for the physician at a children's camp, this book discusses the "total range of health responsibility in camping": camp standards for sanitation, safety, and the health of workers and the medical and surgical problems a camp doctor is likely to meet, including injuries, animal and insect bites, food poisoning, eye problems, infections, and common diseases. Alex H. Kaplan, M.D., of the Washington University School of Medicine, with which the author is associated, contributes a chapter on the psychological problems the camp doctor may meet, such as homesickness, bedwetting, anxiety, phobias, and antisocial behavior.

COMMUNICATION TRAINING IN CHILDHOOD BRAIN DAMAGE. Compiled and edited by Merlin J. Mecham, Martin J. Berko, Frances Giden Berko, and Martin F. Palmer. Charles C Thomas, Springfield, Ill. 1966. 392 pp. $11.75.

The contributors to this volume survey recent advances in and current theories about training children whose abilities to communicate with others through speech, listening, reading, and writing are affected by brain damage. In eight chapters, they discuss such subjects as the disorders of speech and hearing, the role of the speech therapist, the psychological and linguistic meaning of brain damage in children, and special education for the child with brain damage. Their discussion centers on the problems met by those working with such children in psychological testing, speech and hearing therapy, and the classroom.

films on child life

Charges for rental or purchase may be obtained from distributors.

TITLE I—OFF AND RUNNING. 27 minutes (35 mm. filmstrip with magnetic tape sound track, and printed script); color; purchase or loan.

With Johnny Clark, a 12-year-old poverty-stricken boy, as its main character, this filmstrip shows how children who are educationally deprived because of poverty are being helped to learn through special educational programs provided under title I of the Elementary and Secondary Education Act of 1965.

Audience: School boards, teachers, parent-teacher associations, civic groups, and other community organizations; and persons interested in the education of disadvantaged children.

Produced by: Bureau of Elementary and Secondary Education, Office of Education, Department of Health, Education, and Welfare.

Distributed by: For purchase, Coe-Peacock, Inc., 8400 Wisconsin Avenue NW., Washington, D.C. 20014; also available on loan from most State libraries.

FOR BETTER, FOR WORSE. 28 minutes; sound; black and white; purchase.

This film presents a study of the relationships of a teenage boy and a girl following their marriage by documenting one evening in their lives and dramatizing some of the problems they were encountering.

Audience: Adolescents from 14 to 17 in discussion groups concerned with family planning, boy-girl relationships, and sex education; adults in discussion groups concerned with the relationships of parents with their children.

Produced by: TRAFCO-Television, Radio and Film Commission, the Methodist Church.

Distributed by: TRAFCO-Television, Radio and Film Commission, 1525 McGavock Street, Nashville, Tenn. 37203.

PLANNED FAMILIES. 20 minutes; sound; color; purchase.

This animated film, available with sound track in several languages, explains how a baby is conceived and develops, and describes in six detailed segments all the medically approved methods of birth control.

Audience: Patients of maternity and family planning clinics; parent education groups; training classes in family planning for persons in the fields of nursing, medicine, and social work.

Produced by: Allend'or Productions.

Distributed by: Allend'or Productions, 3446 Cahuenga Boulevard West, Hollywood, Calif. 90028.

HERE and THERE

Against discrimination

A children's institution in Denver, Colo., formerly restricted under the provisions of a 19th century will to the care of the poor white "orphan" boys between the ages of 6 and 10 of "reputable" parentage, can now provide care for Negro boys and others who need its services because of a recent court ruling modifying the will's restrictive provisions. The ruling, made by the probate court of Denver early in January in effect eliminated the age, race, poverty, and parental status restrictions in the provisions of a will—made by George C. Clayton in 1892—under which a commission of city officials has been administering the "orphanage," known as Clayton College.

Pointing out that as a "public charitable institution" Clayton College has been enjoying tax benefits not accorded private institutions and that this as well as the involvement of city officials in the administration of the supporting trust had established its nature as a public institution, the court ruled that the provision requiring racial discrimination was in violation of the law of the land. The court also pointed out that if the institution's tax exemption were withdrawn, the trust fund would be so depleted that it could no longer serve the intention of the testator.

Applying the *cy pres* doctrine, which allows a person's testamentary intention to be carried out as nearly as possible when a will's provisions cannot be followed literally, the court interpreted other restricting provisions of the Clayton will as making it impossible for the Clayton Trust Commission to serve the needs of the community and hence to carry out the testator's intention. The court recommended that the word "orphan" be construed to mean the kinds of children most in need of care and that the age limit for admission to Clayton be raised to 18.

Witnesses—representatives of the Clayton Trust Commission, the Denver Welfare Department, and the Child Welfare League of America—had testified that children who need group care today are likely to be older children who need such care on the basis of personal or family situations other than poverty or loss of a parent by death.

The trustees of Clayton College had not acted to expand the institution for some time because the enrollment had dropped to less than half the capacity and, as the commission's witness testified, was likely to drop even more if the conditions of the will were not changed.

The petition to break the will was brought by the city.

. . .

Negro children who attend racially segregated schools do not achieve as well as Negro children in integrated schools, their aspirations are narrower, and they lack confidence in their ability to control the future, the U.S. Commission on Civil Rights maintains in its recent report to President Johnson on racial isolation in the public schools, prepared at the President's request. The community often treats schools in which Negro children are in the majority as inferior, and this view is often shared by administrators, teachers, students, and parents, to the detriment of the Negro child's ability to achieve, the Commission points out.

Based on data from school systems, research sponsored by the Commission, and testimony given in public hearings by school officials, teachers, parents, and civil leaders, the report also includes these observations, among others:

• School segregation is widespread throughout the Nation and is increasing as white people move to the suburbs and leave the city proper to the Negro. Open housing would help break up segregated neighborhoods, but a generation might pass before it could change the composition of the schools.

• Negro children need special attention in school such as small classes and excellent teachers, but, most of all, they need opportunities to associate with advantaged children. Most projects to help overcome the disadvantages of poor environment in large cities have not had lasting effects. Segregated schools in the city cannot be eliminated without the help of suburban schools—both must join together to set up large centers and educational parks where children from many environments will have wide opportunities to learn together.

• The U.S. Congress could help end the isolation of the Negro child by setting up standards for desegregation and programs of financial aid to States to help them meet the standards.

The report, "Racial Isolation in the Public Schools," has been published in two volumes (the second volume consists of appendices). (Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, $1 each.)

Population projections

By 1985 the population of the United States may be one-third again as large as in 1966, according to recent estimates of the Bureau of the Census. Projections in series B (one of four series recently issued by the Bureau, based on different assumptions) show a population of 196.8 million for July 1, 1966; 207.3 million for 1970; 223.8 million for 1975; and 264.6 million for 1985. Behind series B projections is an assumption regarding fertility: that the average number of children per 1,000 women at the end of their childbearing years (15–44) will be about 3,100, or at about the same level as in the years 1964 and 1965. (Provisional figures for 1966 suggest this estimate may be high.)

Coupled with this assumption is the further assumption of a gradually increasing birth rate through 1984 estimated to produce approximately 4.64 million live births a year by 1970; 5.43 million, by 1975; 6.04 million, by 1980; and 6.31 million, by 1985. On this basis the estimated newborn population of 3.89 million in 1966 will increase 19.2 percent by 1970; 39.5 percent by

1975; 55.2 percent by 1980; and 62.1 percent by 1985.

The number of women in the childbearing ages is expected to reach 56.5 million by 1985, increasing from an estimated 39.5 million in 1966.

The number of children under 15 years of age is expected to increase from an estimated 60.1 million in 1966 to a projected 83.1 million in 1985, or about 38.3 percent. The number of people in the age range from 25 through 64 will increase somewhat less rapidly. Thus the ratio of children to adults will increase from 695 children under 15 per 1,000 adults ages 25 through 64 in 1966 to 722 per 1,000 in 1985, about a 4-percent increase in child-rearing responsibility.

The estimates are reported in "Current Population Reports," Series P–25, No. 359, issued by the Bureau of the Census on February 20, 1967. While the figures quoted here are confined to series B alone, the report includes estimates and projections for four series (A, B, C, and D), which differ from one another in respect to assumptions on fertility after July 1, 1966. The assumptions regarding mortality and net immigration are the same in all series. These recent projections differ very little from those published earlier by the Bureau of the Census on March 10, 1966, in Series P–25, No. 329, in which the changes are confined largely to slight rises in the entire population and in births.

A later report in this P–25 series will give complete results and a detailed description of the methodology and assumptions.

Coordinated services

In September of this year, the School of Social Service Administration of the University of Chicago will open a Social Services Center—a multipurpose unit for the Woodlawn community, a low-income area adjoining the university campus. The center is designed to provide the neighborhood with a cooperative network of tax-supported and voluntary agencies working together, under the school's general supervision, to provide more effective services, to develop new programs, and to improve the quality of the agencies' staff through training. Three public agencies providing programs for children and their families will operate in the center at the outset, and the center's staff will make a major effort to bring community agencies not located in the building into close cooperative program development and coordination.

The plan for the Social Services Center is the sequel to a feasibility study made by the school in 1965–66 with a grant from the Children's Bureau. Funds for the building are being sought through the neighborhood facilities program of the U.S. Department of Housing and Urban Development, which has reserved $1,291,000, pending the development of final plans, for a grant requested for the university by the city of Chicago. The building is expected to be ready for occupancy late in 1968.

The opening of the center in temporary quarters this fall before the new building is completed has been planned to provide an opportunity for testing the center's design of operation and new patterns for fieldwork placement of social work students. The initial programs to be included are the maternal and child health services of the Chicago Board of Health, the program of aid to families with dependent children of the Cook County Department of Public Aid, and child welfare, legal services, specialized education, and community organization programs operated by voluntary agencies.

Major organizational elements include provision by the School of Social Service Administration of a program director for each major area of service to provide liaison and coordination, the formation of a council of center-related agencies and organizations, and the establishment of an advisory committee of Woodlawn residents.

The School of Applied Social Services at Western Reserve University and the George Warren Brown School of Social Work at Washington University are now developing similar plans with grants from the Children's Bureau.

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The Secretary of Health, Education, and Welfare has established a departmental committee on children and youth to coordinate all activities and programs within the Department designed to develop the potentials of young people. Under Secretary Wilbur J. Cohen heads the committee; its other members are Philip R. Lee, M.D., Paul A. Miller, and Lisle C. Carter, Jr., assistant secretaries, respectively, for health, education, and individual and family services. In addition to coordinating present programs, the committee is charged with advising the Secretary on new proposals for new programs to help meet the needs of young people in the 1970's.

Agricultural migrants

Texas was the first State to receive a Federal grant under the 1966 amendments to the Elementary and Secondary Education Act of 1965 for a program to improve the education of the children of migrant farm workers. All States except Alaska, Hawaii, and Rhode Island and the District of Columbia—which have no migrant farm workers—are eligible for grants to improve the education of migrant children, and nearly all States have plans either approved by or pending in the U.S. Office of Education.

In Texas, the home base for the bulk of agricultural migrants in the Midwest and western migrant streams, 40 schools in various parts of the State provide 20,000 children of migrant farm workers with a 9-month program of schooling in 6 months, including intensive work in English, reading, science, hygiene, and other subjects. Before the Office of Education grant was made on December 22, 1966, the program received support from the Office of Economic Opportunity.

Other States with approved plans include California, New York, Indiana, Florida, New Mexico, Washington, Colorado, Louisiana, and New Jersey. California will conduct a model program of supplementary education in three counties; New York will offer summer school programs to migrant children; Indiana will train teachers for Spanish-speaking children; and Florida, Alabama, and Georgia plan to establish a coordinated program for migrant children to be administered by the Florida State Department of Education and to involve the development of regional instructional materials, curriculum, and teaching methods, and a method of transferring scholastic and health records.

. . .

A study of child-rearing practices among Negro agricultural migrants in central Pennsylvania has revealed many areas of strength, according to the inves-

tigator, Mable B. Anderson, who carried out the study while working on the staff of a day-care center for migrant children during the summer of 1962. In the study, 64 mothers of 84 children in three Pennsylvania counties were asked about their child-care arrangements and child-rearing practices.

Over half the mothers with children aged 3 to 6 used one of the two day-care centers provided for migrant children between 3 and 11 in these counties. Many mothers, however, took their children under 3, including infants, to the fields with them because they had not been able to make other arrangements and did not wish to leave the children uncared for; and many reported being unhappy about this type of arrangement. All the children over 11 worked in the fields, as did some children as young as 9.

The mothers were not severe in their discipline of the children, not even in toilet training, the investigator found. On the other hand, they were not lenient where sex was concerned: they disciplined the children for sexual curiosity and genital play because they were concerned about the children's health and safety.

The mothers encouraged the children to care for themselves—to bathe and to dress, for instance. In this respect, the children exceeded their mothers' hopes, many mothers reported.

About two-thirds of the mothers said they had received ideas about child care from "medical sources," and many had printed material at hand.

On the whole, the mothers had from 4 to 6 years more education than the mothers studied by other investigators in a survey of east coast migrant workers made at about the same time at another site, and they respected education. While all expressed the wish that their children would get more than an elementary school education, about one-fourth gave some indications that this was either economically or intellectually attainable.

Nearly all the mothers in the Pennsylvania study had received prenatal care; for about half of them the care had begun in the first 3 months of pregnancy—less than 10 percent of the mothers in the other study had received prenatal care as early as this. This difference the study director attributed to the fact that the Pennsylvania migrants had health services available to them at their home base in Palm Beach, Fla.

The differences in the findings among the two groups of east coast migrants Dr. Anderson regards as evidence that generalizations cannot be made on broad groups of people from local studies.

Child care

A cleft palate or lip in a child is not necessarily a deterrent to adoption, the Montana State Board of Health and the State Department of Public Welfare have found. A recent review by Venus Tretsven, coordinator of the cleft palate program, and Wilma Smyth, medical social consultant, of the State Board of Health's division of child health services, of the 337 children with clefts born in the State between 1955 and 1965 showed that 8 of the 11 needing families other than their own have been placed in adoptive homes. Except for one who died from a sudden infection, the children are getting along well. The adopted children include both Indian and Caucasian children, several of whom have more than one handicap—one, for example, is mildly retarded; another has deformities of hands, feet, and neck.

The adoptions followed close work between the social workers of the State Department of Public Welfare and the Lutheran Social Services, the agencies responsible for the placements; the specialists of the cleft palate teams of the State Board of Health; and the local public health nurses.

One of the three children remaining in foster care—where they were placed because of parental neglect—has been relinquished by his parents for adoption also, although adoptive placement has not yet been made.

. . .

For a child-caring agency to act as a "parental force," accepting responsibility for all aspects of a child's life can effect greater stability in emotionally disturbed children in foster care, according to a study conducted by the Iowa Children's Home Society, in Des Moines, with a demonstration grant from the Children's Bureau. Though the agency, a voluntary child-care agency, set out to determine whether the "split case" method—having one caseworker act as a therapist and another as a "parental force"—or the "single case" method—having one caseworker perform both functions—was more effective in helping the emotionally disturbed children selected for the project, the agency found that all the children improved. The study included 24 children, aged 7 to 16, from similar backgrounds who were in foster families, group homes, or residential treatment centers and were expected to need care away from their own parents for at least 2 years. They were assigned at random to the two methods.

As the "parental force," the agency provided the children with an "underpinning of authority" that supported the needs of the children and was a constant factor in their lives, according to the project's director, Edith Zober. She reports that the children seemed to know that the agency was acting as a parent in assuming ultimate responsibility for all aspects of their lives—school, foster home adjustment, peer adjustment, and, in some instances, beginning adjustment to work.

As a result of the project, the agency has defined its primary method of working with emotionally disturbed children in foster care as reestablishing a functional parent for the child.

Education

By the first of March this year, 64 projects to improve the education of the nearly 50,000 children attending the schools operated by the Bureau of Indian Affairs, U.S. Department of the Interior, had been approved for grants from the Office of Education, U.S. Department of Health, Education, and Welfare, under the 1966 amendments to the Elementary and Secondary Education Act of 1965.

The grants have been made for improvements of classwork, cultural enrichment, and the meeting of special needs in day schools and boarding schools operated by the Department of the Interior. They are, for example, providing for additional teachers and teachers' aides to facilitate language instruction, summer programs, and preschool, remedial, and enrichment activities and to reduce the size of classes; guidance counselors and school social workers; food and transportation services; the expansion of physical education and recreation programs; special education of the handicapped; and special services for pregnant girls.

IN THE JOURNALS

Treating the whole family

Pointing to the importance of having a treatment goal for each member of the family, Otto Pollack, in the March 1967 issue of *Child Welfare*, suggests that team counseling of the family as a group be used not only for intact families with problems of intrafamily relationships but also for broken families, adoptive families, and foster families. ("Disturbed Families and Conjoint Family Counseling.")

The author, who is professor of sociology at the Wharton School, University of Pennsylvania, also suggests that the content of family therapy with the different types of families will vary. For example, he says, with broken families it may include coping with problems of guilt, anger, and fatigue not likely to appear in intact families and with pressures on the remaining members to take over the role of the absent member; with foster families, problems connected with the demand for emotional commitment without the security of permanence, the experience of sibling rivalry and intimacy without the correctives of a blood relationship or incest taboo, and the threat of parental autonomy represented by the caseworker or the child's own parents; with adoptive families, some of the same problems connected with the absence of blood tie controls as in foster families, or concern over an equitable distribution of the parents' affection between their natural and adopted children. The author further suggests that two therapists—a man and a woman—working with the family as a team can provide the members of a foster or adoptive family with a model for impulse control.

Tracing the development of family group therapy in the past decade, from the recognition of therapists more than 20 years ago that improvement in one member of a family following individual therapy of sometimes accompanied by deterioration of another, the author maintains that conjoint family therapy, whether provided by a team or an individual therapist, can restore communication between the members of a disturbed family who have built "walls of psychological privacy" around themselves and can thus begin the healing process.

Family law

A new journal, *Family Law Quarterly*, published by the American Bar Association, Section of Family Law, which made its initial appearance in March of this year, will, according to the preface, concern itself "not merely with those questions which are now clearly in the domain of family law (e.g., alimony, adoption, divorce)" but also with subjects "with which lawyers handling domestic relations should be familiar" such as marriage counseling, the rights of children who do not live with both parents, and proposals concerning a change in abortion laws.

Among the articles in the first issue is one commenting on three 1966 custody decisions in Iowa in each of which a parent was denied custody of a child he or she had once voluntarily placed with the child's grandparents. ("Child Custody: Iowa Corn and the Avant Garde," by David N. Levine.) The author points out that in each case (*Painter* v. *Bannister*, 140 N.W. 2d 151; *Alingh* v. *Alingh*, 144 N.W. 2d 134; and *Halstead* v. *Halstead*, 144 N.W. 2d 861) the Supreme Court of Iowa placed the doctrine of "the best interest of the child" above the "natural right" of the parent to the child. Finding in these decisions a definite advance over the "unfortunate vestige of the feudal era," rigid adherence to the natural right theory, the author, however, warns against just as rigid adherence to a *parent by association* doctrine without giving serious consideration to psychological and psychiatric testimony. Pointing out the difficulties of arriving at the "best interests of the child" in a case like the highly publicized Painter case, in which the suing father, "a wholly fit person" had after his wife's sudden death relinquished custody of his son only temporarily to the maternal grandparents for whom the boy proceeded to develop a strong attachment, he concludes that the final judgment must be the court's, but that judgment must follow intelligent appraisal of the case and not be "rigidly predetermined."

Family planning

Because of the lack of clarity as to the nurse's role in family planning today, nursing education programs need to integrate family planning concepts and skills into their basic nursing curriculum, says Sister Mary Helen, coordinator of maternal-child nursing, University of San Francisco School of Nursing, in the March 1967 issue of *Nursing Outlook*. ("Family Planning Within the Curriculum.") This approach, she says, will enable nurses to function effectively in any family planning program. However, she adds, planning for such a program must take into account the institution's philosophy and the ideas, previous experience, and cultural background of the teachers and the students who are to participate.

The author describes the principles followed in incorporating family planning content into the University of San Francisco's baccalaureate nursing program, which is developed on three "core threads"—family-community health, problem-solving, and leadership. She cites the following goals for the student:

- The formulation of a realistic, satisfying personal attitude about sexuality and her role as a woman.
- The ability to apply problem-solving methods to patient situations as well as to her own.
- The development of skill in interviewing.
- An understanding of the need for family limitation as a social as well as an individual family problem.
- Recognition of the goal of family planning as strengthening the family.
- Recognition and respect for the rights of individual couples to choose their family size.
- Knowledge of the various methods of birth control and a demonstrated ability to explain their use.
- Understanding the nature of the

nurse's role in family planning programs.

• Awareness of her own limitations, and ability to seek counsel when indicated and to refer patients to appropriate resources.

Living with leukemia

The old theory that the less children with leukemia discuss their problems and progress, the less upset they will be is no longer accepted at the leukemia service of the National Cancer Institute, write Joel Vernick, former social worker in the institute's children's program, and Janet L. Lunceford, head nurse of the cancer nursing unit, in the March 1967 issue of the *American Journal of Nursing*. ("Milieu Design for Adolescents with Leukemia.")

The article describes the institute's program of providing adolescent leukemia patients with opportunities to discuss their fears, anxieties, and problems in unscheduled individual or group interviews with the nursing unit's social worker and nursing staff. This program, which includes all children ages 9 through 21 admitted to the service, has resulted in lessened anxiety and in more healthy emotional functioning among them, the authors report.

The young people are given frank answers to their questions but are told there is always hope and that everything possible is being done to get them well enough to return home. Questions that cannot be answered by the social worker or nursing staff are referred to the chief pediatrician.

The authors also point out that the children are encouraged to function as normally as possible—to attend school in the building when they can, keep their rooms neat, obey the hospital rules, and participate in and attend recreational activities such as gym exercises, arts and crafts, weekly movies, band concerts, picnics, sightseeing tours, and trips to the drugstore. Bedside programs of occupational therapy are offered when necessary.

High risks of schizophrenia

Children of two schizophrenic parents have about a 35-percent "risk rate" of developing schizophrenia, as compared with the 1-percent risk rate among children in the general population and a 7- to 15-percent risk rate among children with one schizophrenic parent only, reports David Rosenthal, chief of the laboratory of psychology at the National Institute of Mental Health, in analyzing five studies of children of schizophrenic parents in the December 1966 issue of the quarterly *Journal of Psychiatric Research*. ("The Offspring of Schizophrenic Couples.") The studies included 99 children of 65 schizophrenic couples.

The author presents evidence both for and against the implication of a dominant gene in the development of the disease and concludes that both genetic and environmental factors are involved. Reflecting on "what the home life of a child with two schizophrenic parents must be like," he points to the difficulty of distinguishing between the extent of the influence of "domestic chaos" and of "genetic chaos" on the rate of schizophrenia among such children.

According to the author, the findings also indicate that perinatal mortality is higher among infants born to schizophrenic parents than in the general population, that it is higher among children whose mothers only are schizophrenic than among children whose fathers only are schizophrenic, but that it is no higher among the children with two schizophrenic parents than among children whose mothers only are schizophrenic. Here again, he suggests, there is difficulty in determining how much of the differences in rate can be laid to the effects of the disease-carrying gene on the fetus and how much to noxious factors derived from the mother's schizophrenic state, such as the ingestion of drugs, coma or convulsion inducing treatment, inadequate diet and exercise, and prolonged anxiety.

guides and reports

FAMILY PLANNING PROGRAMS IN THE WAR AGAINST POVERTY: a guide for community action programs. Planned Parenthood-World Population, 515 Madison Avenue, New York, N.Y. 10022. 1966. $3.

A kit of guide materials for developing a local family planning program.

TRAINING SERIES FOR SOCIAL AGENCIES—Vols. I through VIII: Implications of Social Change; Changing Interpretations of Behavior; Social Agencies and Social Change; Poverty in the United States; Reaching the Disadvantaged Child; Dropouts and Training; Delinquency and Treatment; and Planned Change. Edited by Robert Schasre and Jo Wallach. Youth Studies Center, University of Southern California, Los Angeles, Calif. 90007. May 1966. $1.50 each.

A reading series of published and unpublished material focused on the poor and culturally disadvantaged for use in education and training in the field of social service.

REARING CHILDREN OF GOOD WILL: a program guide. James M. Eagan. National Conference of Christians and Jews, 43 West 57th Street, New York, N.Y. 10019. 1966. 38 pp. 35 cents.

Offers suggestions for helping children in the home, school, church, and community grow up without prejudice toward others of different race, religion, or national origin.

GUIDE FOR ESTABLISHING AND OPERATING DAY CARE CENTERS FOR YOUNG CHILDREN. Dorothy Beers Boguslawski. Child Welfare League of America, Inc., 44 East 23rd Street, New York, N.Y. 10010. 1966. 100 pp. $2.50.

Describes the purposes and program of a day-care center for children, the roles of various types of staff members, housing and equipment needed, the sources of financial support, and the importance of a State licensing law.

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U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

SUMMER EDUCATION FOR CHILDREN OF POVERTY: report of the National Advisory Council on the Education of Disadvantaged Children. Department of Health, Education, and Welfare, Office of Education. OE–37006. 1966. 54 pp. 40 cents.

On the basis of the reports of 27 consultant-observers appointed by the Advisory Council, describes and evaluates the 1966 summer education projects for disadvantaged children in 86 school districts in 43 States. The projects received support under title I of the Elementary and Secondary Education Act of 1965.

GRANTS-IN-AID AND OTHER FINANCIAL ASSISTANCE PROGRAMS ADMINISTERED BY THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. 1966 Edition. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Program Coordination, Office of Program Analysis. 1966. 527 pp., plus fold-in tables. $3.50.

Reports on the background, purposes, financing methods, application procedures, and legal basis of the 190 financial assistance programs administered by the Department's constituent agencies.

SPOTLIGHT ON DAY CARE: proceedings of the National Conference on Day Care Services, May 13–15, 1965, Washington, D.C. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 438. 1966. 173 pp. 55 cents.

Contains a report of the preconference meeting, the addresses given at the conference sessions, and the recommendations made by its work groups.

DOCTORAL DISSERTATIONS IN SOCIAL WORK RELATED TO THE FIELD OF CHILD WELFARE. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 21 pp. Single copies free from the Bureau.

Lists 117 of the doctoral dissertations accepted from 1920 through June 1965. Their subjects fall into 36 areas of concern, the most frequent being juvenile delinquency, observation and measurement of child behavior, and aid to families with dependent children.

FAMILY PLANNING AND MENTAL HEALTH: summary of discussions held at the National Institutes of Health, January 13, 1966. Population Crisis Committee, 1730 K Street NW., Washington, D.C. 20006; and Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, Bethesda, Md. 20014. 1966. 38 pp. Single copies free from the Committee or the Institute.

Considers the relationship between family planning and mental health and ways of coordinating programs in these two fields.

PROCEEDINGS OF THE INTERNATIONAL CONGRESS ON HOME HELP SERVICES. Held in Koenigstein, Germany, Sept. 8–11, 1965. (English translation.) Department of Health, Education, and Welfare, Welfare Administration. WA Publication No. 17. 1966. 102 pp. 35 cents.

The official report of the conference.

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